DOCUMENT RESUME

ED 383 429 PS 023 232

AUTHOR	Clark, Dick
TITLE	The Challenge of Parenting in the '90s. Proceedings of the Aspen Institute Congressional Program (Naples, Florida, February 17-20, 1995).
INSTITUTION	Aspen Inst., Queenstown, MD.
SPONS AGENCY	Carnegie Corp. of New York, N.Y.
REPORT NO	ISBN-0-89843-168-9
PUB DATE	95
NOTE	64p.
AVAILABLE FROM	Aspen Institute, Publications Office, P.O. Box 222, 109 Houghton Lab Lane, Queenstown, MD 21658 (Publication No. 95-W633, $5).
PUB TYPE	Collected Works - Conference Proceedings (021) -- Collected Works - Serials (022)
JOURNAL CIT	Congressional Program; v10 n1 1995
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Adolescents; *Child Rearing; *Early Parenthood; Family Programs; *Parent Education; Parenting Skills; Parent Role; Parents; Pregnancy; Public Policy; Youth Problems
IDENTIFIERS	*Family Support; School Based Services

ABSTRACT

This Conference focused on policy options for promoting the well-being of children and families in the United States. These conference proceedings present a range of strategies that have proven effective in building parental competence and providing the support needed to enable families to survive and function adequately. The keynote address, "The Challenge of Parenthood" (D. Hamburg), describes the dramatic changes that have taken place in families' lives in recent decades and the formidable challenges facing today's parents. The following articles are then presented: (1) "Preparation for Parenthood" (S. Brown); (2) "Promising Preventive Interventions during Pregnancy, Infancy, and Early Childhood" (D. Olds); (3) "On Building Parental Competence: The Nature of Contracts and Commitments" (S. Kagan); (4) "Avance Family Support and Education Program" (G. Rodriguez); (5) "Parenting Adolescents: What Legislators Can Do to Support Families" (R. Takanishi); (6) "How Parents Can Obstruct and Enhance Adolescent Development: Some Observations and Policy Implications" (S. Hauser); and (7) "Full Service Schools" (J. Dryfoos). (AP)

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CONGRESSIONAL PROGRAM

THE CHALLENGE OF PARENTING IN THE '90s

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THE CHALLENGE OF PARENTING IN THE '90s

February 17–20, 1995

Dick Clark

The Aspen Institute
Queenstown, Maryland
1995

This project was funded by the Carnegie Corporation of New York. The contents of the report and the background papers should not be construed as reflecting the views of the Carnegie Corporation or The Aspen Institute.

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The Aspen Institute
Suite 1070
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036
Published in the United States of America
in 1995 by The Aspen Institute

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Printed in the United States of America

ISBN #0-89843-168-9

Table of Contents

Rapporteur's Report 1

The Challenge of Parenthood 11
David A. Hamburg

Preparation for Parenthood 15
Sarah S. Brown

Promising Preventive Interventions During Pregnancy, Infancy, and Early Childhood 19
David Olds

On Building Parental Competence: The Nature of Contracts and Commitments 25
Sharon L. Kagan

Avance Family Support and Education Program 33
Gloria G. Rodriguez

Parenting Adolescents: What Legislators Can Do to Support Families 39
Ruby Takanishi

How Parents Can Obstruct and Enhance Adolescent Development: Some Observations and Policy Implications
Stuart T. Hauser 45

Full Service Schools 51
Joy G. Dryfoos

List of Participants 57

Conference Agenda 59

Rapporteur's Report

Dick Clark, Director and Moderator

Carol Copple, Rapporteur

The Challenge of Parenting in the '90s was the theme of a conference sponsored by The Aspen Institute Congressional Program, held from February 17 to 20, 1995 in Naples, Florida. The meeting was the fifth in a series focusing on policy options for promoting the well-being of children and families in the United States. Each of the first three conferences, conducted by The Urban Institute, and the 1994 conference directed by The Aspen Institute, has dealt with a different topic affecting children. The central theme of parenting, as well as the topics within this theme, was selected for its relevance to present and future policy issues facing Congress. Three senators and twelve members of the House of Representatives participated, along with ten experts with scholarly and practical knowledge of the problem area.

Like previous meetings in the series, this conference was not intended to yield a consensus statement on recommended policy directions. Rather, it was designed to extend and enrich the Members' understanding of the increased difficulties of parenting today, the inadequacies in family life that many children are experiencing, and the serious impacts of these on children and the whole of society. Also described were actions that have proven most effective in confronting the complex set of problems relating to parenting. The conference series seeks to contribute not through producing policy conclusions but through facilitating the search for common ground on which effective American legislative policy must rest.

The three-day agenda was organized in terms of the developmental stages of parenthood, from conception and pregnancy to parenting children from infancy through adolescence. Throughout the meeting, experts presented a range of strategies that have proven effective in building parental competence and providing the support needed to enable families to survive and function adequately.

In his keynote address, David Hamburg described the dramatic changes that have taken place in families' lives in recent decades and the formidable challenges facing today's parents. Perhaps most striking of the changes has been the rapid entry of mothers of young children into the workforce. As of 1990 over half of all American mothers of young children work outside the home, and parents face the difficult task of integrating work and family responsibilities. The total time that parents spend with their children has diminished by about one-third over the past 30 years. Further, most American children today spend part of their childhood in a single-parent family. The revolving door of repeated marriages and divorces, of multiple attachments and disruptions—a pattern that is not found in other countries—adds stresses to the lives of children and adolescents. With such radical shifts in family life, it is not surprising that American parents express disquiet about raising their children.

By a wide variety of indices, this country is suffering heavy casualties during childhood and

adolescence—in educational failure, poor health, violence, and other very high-risk behavior. In the face of drastic changes in family life and other circumstances of jeopardy, ways must be found to strengthen the conditions for healthy child development. Fortunately, there is research evidence and carefully assessed innovations on which to base actions. Within the scientific and professional communities, a strong consensus is emerging on the conditions that influence child and adolescent development, including the aspects of parenting that make the most difference.

It is now known that the time from conception through the third year is particularly momentous for the child's development—for better or for worse. A poor start leaves a legacy of impairment, with very high costs to follow for the entire society. The *Starting Points* report, issued in 1994 and based on the work of the task force set up by Carnegie to study the years zero to three, stresses the need to mobilize all sectors of society and government—media, science, business, clergy, non-profit organizations, as well as local, state, and federal government—to confront these problems. The need for broad community mobilization is equally applicable in tackling the problems of older children and adolescents. If a broad public consensus emerges, and children's needs and constructive policy options are fully considered, there could be a real transformation in the health and well-being of American children.

The first session, "Preparation for Parenthood," was introduced with papers by Sarah S. Brown and David Olds.

Well before the child is born, certain forces begin to affect parents' ability to do their job well. Two are particularly powerful: first, the extent to which the pregnancy (and thus parenting) is actively planned and intended; and, second, the nature and timing of prenatal care.

About 60 percent of all pregnancies in the United States are unintended—a far higher percentage than in other Western democracies—and about half of these are terminated by abortion. Of the women who carry unintended pregnancies to term, about half have not come to regard the pregnancy positively by the time they give birth. Contrary to common assumption, teenagers represent only about a fifth of all unintended pregnancies, although a high proportion (73 percent) of all adolescent pregnancies are unintended. Among unmarried teens, 86 percent of pregnancies are unintended. With the age of menarche steadily dropping and marriage being delayed to later ages, young people are at risk for non-marital childbearing for a far longer period than in the past.

At any age, unintended pregnancy has serious, long-lasting consequences, imposing substantial burdens on parents and their children. A woman with an unintended pregnancy is less likely to seek early prenatal care and more likely to expose the fetus to noxious substances (e.g., alcohol, nicotine, and illegal drugs). Further, the child of an unwanted conception is at greater risk of being born at low birth weight, of dying in the first year of life, of being abused, and of not obtaining enough resources for healthy development. The mother herself may be at greater risk for depression and physical abuse, and her relationship with the male partner is more likely to dissolve. When an unintended pregnancy occurs, both mother and father often suffer economic hardship and fail to achieve their educational and career goals.

The extent and consequences of unintended pregnancy are poorly appreciated in the United States. Concern about teenage pregnancy and illegitimate childbearing is mounting, and the violent controversy over abortion continues to escalate, yet the common link among all three—pregnancy that is unintended at conception—is virtually invisible. As a result, most proposed remedies ignore the common underlying cause. Pregnancy planning is not included as a central, routine component of health and social services, especially preventive health care and education. Pregnancy prevention and family planning are typically treated as marginal activities. By contrast, a great deal is being said today about promoting sexual abstinence—certainly pertinent for young teenagers but less so for the large proportion of unintended pregnancies that occur when the partners are older and often married. Moreover, providing contraceptive information and services along with promoting abstinence has not been found to undermine the abstinence message, as some people have feared. Young adolescents are able to absorb the twofold message: abstinence is a much better course for the young and unmarried, and contraception is imperative in sexual encounters that do occur. Good programs teaching this double

message have succeeded in both delaying the age of the first sexual encounter and increasing the use of contraceptives when sex does occur.

Available research and public health experience indicate that significantly reducing unintended pregnancy in the United States will require a public-private, multifaceted, and long-term effort (much like the anti-smoking campaign) to:

- improve knowledge about contraception, unintended pregnancy, and reproductive health;
- increase access to contraception;
- explicitly address the major role that motivation plays in using contraception and avoiding unintended pregnancy;
- develop and scrupulously evaluate a variety of local programs to reduce unintended pregnancy; and
- fund research to develop new contraceptive methods and to answer important questions about how to organize and support contraceptive services.

It is noteworthy that in Western Europe and Canada, where unintended pregnancy is far less common than in the United States, certain conditions exist: The health system is accessible to all; contraception is free or inexpensive and easy to obtain; and a clear message is consistently conveyed—across the education system and media, as well as in the family—that teen pregnancy is unacceptable. In addition, most young people in these countries have a strong social support system and a sense of their future.

Another dimension of "pre-parenthood" that has momentous implications for the well-being of children and families is prenatal care. Over the last decade there has been a growing understanding that prenatal care improves children's developmental prospects and that improved access to this vital service is needed. Among the well-documented benefits of prenatal care are reduced infant mortality and low birth weight, which in turn means fewer respiratory tract infections, congenital anomalies, and neurodevelopmental handicaps. Any reduction of these disabilities is enormously important in economic and human terms, since even subtle damage to the fetal brain may have devastating effects on a child's development.

Further, the prenatal interval is increasingly recognized as a "teachable moment" that offers unique opportunities for education, support, and future planning. Aside from reducing pre-term delivery and low birth weight and the aftermath of related problems, preventive interventions during and after pregnancy can help to reduce childhood injuries, as well as child abuse and neglect. Comprehensive interventions during and after pregnancy have produced significant reductions in later pregnancies and increases in the number of young women continuing their education—two factors closely linked to self-sufficiency. Two types of preventive intervention models have shown promising results: the school-based model and the home-visitation model. Both approaches must be intensive in nature and sustained in duration in order to bring about substantial results in the lives of the young parents and their children.

The Polly T. McCabe School-Based Program in New Haven, Connecticut, is one of a number of programs around the country designed for pregnant students who might otherwise drop out of school. Young women are referred from their regular schools when pregnancy becomes apparent, and they typically remain at McCabe for the academic quarter during which they deliver the baby. The program offers small classes, individually-paced instruction, personal guidance, and mentoring by teachers, nurses, and social workers. Students are helped to plan for self-sufficiency, including delaying subsequent pregnancies. Students receiving services early in gestation have lower rates of pre-term delivery and low birth weight than those receiving services later in the pregnancy. School-based programs like Polly T. McCabe represent a new wave of programs that are not only more programmatically powerful than those in the past but also more rigorously evaluated.

Another such approach is home visiting by nurses during pregnancy and the early years of the child's life. In one such program (more fully described in the paper by David Olds), implemented in Elmira, New York and Memphis, Tennessee, the nurses made 8 visits during pregnancy and 25 visits from birth through the second year of the child's life.

From these studies and a review of other randomized trials of pregnancy and infancy home visitation programs, certain key factors emerge: the more successful programs focused their services on families in greater need for the service, and they used nurses who visited frequently beginning during pregnancy and continuing at least through the second year of the child's life. Visitors were well trained to promote positive health-related behaviors and infant caregiving and to reduce family stress by improving families' social and physical environments.

Across program models, what seems critical is enabling young people to develop a sense of the future, a sense of hope—and the concrete skills they need to realize their hopes. Young people change their lives only when they recognize that they have real options and that what they do in the present matters, whether it is refraining from smoking during pregnancy, continuing their education, delaying future pregnancies, or being responsible and nurturing parents.

Ezra Davidson further explored the components and benefits of comprehensive prenatal care from the perspective of clinical experience in an urban setting serving a population at high risk. In addition to reducing maternal and infant mortality and morbidity, comprehensive prenatal care is increasingly directed toward a broader set of goals, including promoting parenting skills; supporting healthy growth and development, immunization, and health supervision; and reducing child abuse and neglect, injuries, and preventable illness. The reduction of postpartum hospitalization in recent years is an additional factor increasing the importance of making use of the prenatal interval as a learning opportunity.

Comprehensive prenatal care probably achieves some of its impact through the fact that in entering prenatal care the woman enters another "culture," a culture of conversation and concern about her health and what is good for the baby. When someone calls her if she misses an appointment, she feels that she and her baby matter. In efforts to change maternal behavior, a highly potent force is reaching the partner. For example, if the young man becomes convinced that smoking is bad for the fetus, he may try to get the woman to refrain from smoking during her pregnancy. The woman sees her partner far more frequently than she does the physician, and she also is more likely to be influenced by what the partner says. Involving fathers positively in the child's life beginning in the prenatal period is critical, along with strict child support enforcement. Little is known about how to promote their involvement, although responsible fatherhood groups in some cities are beginning to show that it is possible.

The second session, "Building Parental Competence," was introduced with papers by Sharon L. Kagan and Gloria G. Rodriguez.

Parent education and family support have a long and varied history, ranging from informal helping by extended family or neighbors to more organized education and services, such as those provided by settlement houses at one time. Until a few decades ago, the prevailing model was "top-down," that is, the wise expert providing knowledge and assistance to the "empty-vessel" client. Beginning in the 1960s, the War on Poverty and the civil rights movement energized commitments to greater parent involvement and empowerment through the provisions for policy making in Head Start, the provisions of Title I of the Elementary and Secondary Education Act, citizen control of education, and the due process provisions of the Education for All Handicapped Children Act of 1975.

Today a wide array of parent education and family support services are provided through many different programs, varying in sponsorship, funding mechanisms, participants, comprehensiveness, staffing patterns, and evaluation strategies. Some programs were established primarily to provide such services, but in many cases parent education and support were a natural expansion of ongoing work. Though each of the programs is especially designed to serve certain kinds of family needs, most share a set of basic characteristics. Family members are regarded as full partners and are deeply engaged in all stages of the process, rather than simply being passive clients waiting to receive services. In the same vein, programs do not encourage dependence on service providers but value parents' independence and support of one another. Parent education and support programs as a group stress prevention rather than treatment. Finally, programs recognize the need to work with the entire family and community, while nurturing cultural diversity.

Despite the considerable unanimity on these principles and on the need for enhanced education

and support services for families, certain key issues remain to be resolved. Since low-income parents have far more limited access to formal parenting programs than do more affluent parents, and less money with which to buy information, *equity* is a major issue. Also, most parent education and support programs now are entirely *voluntary*, but the critical importance of parenting for our whole society leads to the idea of requiring some minimal level of parenting education, for example, in order to qualify for the earned income credit or tax exemption that now is received automatically. This idea holds promise, but policy makers also need to be mindful that shifting from voluntary to required participation might fundamentally alter the nature of family support and education and thus undermine effectiveness. Incorporating parenting education in life skills courses in middle school and high school is another alternative that is beginning to receive attention.

In this fast-growing field, there is wide divergence in the credentials, training, and competencies of those working in the programs, and thus the *quality* of services needs to be considered. Moreover, the *impact* of family education and support programs as a group is hard to judge because some are more effective than others and few have been systematically evaluated. With parent education programs bubbling up rapidly under many different auspices, the issue of *linkage and coordination* also arises, and the need for cooperative planning and coordination of service delivery is becoming acute.

Assuming that parent education and family support are deemed important endeavors, four strategies are open to policy makers. Parent education and support services could be classified a merit good, along with libraries, parks, or schools, and supported accordingly. At the other end of the continuum, parent education might be left entirely to the free market. A third option midway between the merit-good and free-market approaches is a targeted strategy: some parent education and support programs would be nurtured by leveraging the market, while families unable to purchase in the market would have access to publicly supported services, through extension of such programs as Family Preservation and Support, Even Start, Head Start, Family Literacy, and the Comprehensive Child Development Program. The potential disadvantage of this targeted approach is stigmatizing services and segregating families by income. Some form of sliding scale or voucher system might be used to mitigate this segregating of services.

A final strategy, which transcends the other three, is to assess each new piece of legislation in terms of its consequences for families and to infuse parent education and support into the full range of social supports, including welfare reform, job training, employment, and parental leave. Scaling up from small, community-based programs to reach all families in need of parent education and support would be daunting if it meant attempting to replicate a self-contained, locally successful program in hundreds of communities around the country. More feasible is applying the lessons and principles gleaned from successful programs within present institutions and structures.

The guiding principles of family education and support—and their contribution to program effectiveness—can be seen in action in the Avance Family Support and Education Program, one of the first comprehensive, community-based, family support programs to target predominately poor Hispanic populations. Begun in 1972 with foundation funds, Avance now receives funding from a broad array of corporate, foundation, municipal, and federal sources. The program provides services to 50 family centers located in schools, churches, public housing developments, Boys and Girls Clubs, and community centers in San Antonio, Houston, and southern Texas. The core is a nine-month intensive parent education program that includes a 30-unit curriculum, along with toy-making, home visits and home teaching, community resource awareness, child care while parents are in class, and transportation.

Avance epitomizes the "one-stop shopping" model that makes accessible to at-risk families a wide variety of social services and supports, including health care, adult literacy training, youth development and job skills training, job placement, housing assistance, and substance abuse treatment. Children participate in Head Start and other early childhood programs; and in the public schools they receive tutoring, mentoring and other supports to help them succeed. Scholarships are available for young people who graduate and want to go on to college.

Although this broad, coordinated array of services is invaluable to participating families, Avance does more than provide a cafeteria of services. What

is vital to its success is building and maintaining relationships—between program staff and participants, neighbor to neighbor, and family member to family member. The primacy of relationships in helping people change their lives also means that such "distance learning" methods as parenting videotapes or television programs—except as a part of broader and more sustained efforts that actively engage individuals—should not be expected to succeed with at-risk families.

The pivotal importance of relationships in parent education and family support also has implications for staffing: it is advisable to hire caring people who are familiar with participants' lives, and then to give these individuals the training and tools needed to work effectively in new roles. It was argued that this approach is more effective than hiring highly-trained professionals who lack the kinds of experience and attitudes important in doing the job well. Avance employs many of its own graduates, who not only relate readily to the problems of the parents but also provide role models with whom the parents and children can identify. In programs across the country, a balance of professional and paraprofessional staff has been found most effective. Additionally, programs have a better chance of long-term survival and success when people in key roles are skilled not only as leaders and trainers but as managers as well.

Evaluation of the Avance program has yielded very encouraging results. For example, while dropout rates typically run from 50 to 80 percent for this population, 94 percent of participants' children (at the time of the study) had either completed high school, received their GED, or were still attending high school. Of the high school graduates, 43 percent were attending college.

As for the documented impact of family-focused interventions other than Avance, results are encouraging, though the knowledge base is still quite limited. Well-conceived, comprehensive programs clearly are able to improve parents' attitudes, skills, and competencies. They produce very strong positive effects on mothers' functioning and interaction with their children, parents' education, parent and child health, and pregnancy planning. Also well documented are the dramatic benefits to infants who are biologically at high risk. More tenuous is the link to measurements of children's cognitive development. On the whole, programs serving populations at greater risk have shown greater gains than have other programs.

Further examining the challenges facing parents in the '90s, Eleanor Maccoby introduced a discussion of the multiple roles that today's working parents manage and the implications for policy. With the enormous increase in dual-earner households with children have come dramatic changes in the care of American children, both within the home and in child care settings.

Research indicates that even in dual-earner families, men do little to share the load of household and child-related duties. Working mothers interact with their children far more than working fathers do; women also do most of the housework, even when they are employed full time. The burden of this "second shift" for women is manifest in physical indices of stress: When both working parents return home, the father's stress level goes down and the mother's goes up. Such pressures are exacerbated for single mothers.

While parents are working, their children are cared for mostly by poor and minority women. The quality of family child care and care by relatives, as revealed in a large-scale national study, is disturbingly poor.[1] Recently released are the results of the first comprehensive econometric and psychometric analysis of center-based child care and children's outcomes in the U.S., suggesting serious deficiencies in quality.[2] Although child care centers vary widely between and within states and sectors of the industry (e.g., for-profit and non-profit), most child care is mediocre in quality—poor enough to impede children's emotional and intellectual development. Overall, the worst care is for children under the age of three, when children's development is especially vulnerable. Not surprisingly, states with more demanding licensing standards were found to have fewer poor-quality centers. Aside from state licensing requirements, the best predictors of child care quality were staff-to-child ratios, staff education, administrators' prior experience, and teacher wages.

With respect to the documented link between cost and quality, it is noteworthy that the United States government pays far less of the total child care bill than do the governments of other technically advanced democracies. For example, U.S. parents pay 72 percent of child care; Japanese parents pay only 20 percent, while the government pays 80 percent.

With evidence of widespread poor-quality child care around the country, especially for younger children, actions to give more parents a realistic option of staying home with children for a longer time belong on the table for policy makers' consideration. The parental leave law only applies to businesses with 50 or more employees, and 60 percent of Americans work for smaller companies. Even for those families now eligible for parental leave, the 12-week guaranteed leave is likely to be insufficient for solid mutual bonding, establishing the infant's routines, and allowing parents to get adequate sleep at night. In addition, U.S. parental leave policies do not provide for wage replacement, which means that less affluent parents often cannot afford to avail themselves of the leave. Countries with parental leave policies, which includes most of the technically advanced democracies, typically provide wage replacement. Some cover up to 100 percent of the employee's wages; others pay a lower percentage. In considering policies for wage replacement in the U.S., policy makers should be aware that: (a) the higher the percentage of wages replaced, the greater the proportion of families who would opt to stay home with their children for a longer period of time; and (b) the cost of wage replacement would be less than the cost of public support of child care, even aside from benefits to the child and parent.

The third session, "Parenting Adolescents" was introduced with papers by Ruby Takanishi and Stuart T. Hauser.

Within our lifetimes large-scale economic and sociocultural transformations have brought about seismic changes in American families, with serious repercussions for the lives of adolescents and their parents. Equally dramatic are the risks and choices encountered by adolescents at increasingly younger ages—choices about drug use, sexuality, and use of lethal weapons, to name a few. Moreover, in contrast to widespread recognition among Americans that parents are crucial in the lives of their infants and young children, social consensus is lacking on the role of parents in the lives of their adolescent children. For instance, should parents step back and give teenagers lots of room to develop in their own ways, or should they "crack down" in an effort to keep the lid on? By adolescence, is it too late for parents, or anyone, to make a difference? Such uncertainties and the many dangers of our times lead to withdrawal from adolescents by parents and others in society.

The new family landscape, brought about by rapid changes in the American economy and society, has several additional features that deeply affect the lives of adolescents and their parents: (a) diminished support from relatives and other sources, partly from greater mobility; (b) age segregation throughout society, with the effect of increasing peer influence; and (c) less time for adult guidance, supervision, and transmission of values, especially in dual-earner and single-parent families.

Although research, practice, and policy with respect to adolescence and parenting of adolescents are far less developed than for early childhood, an upsurge of activity in the last 15 years has greatly expanded the knowledge in this area. Much can be done to strengthen and support the families of adolescents, as well as to help adolescents themselves outside the family context. One finding that comes through clearly is that adolescents need and want a relationship with their parents; in survey after survey young people from all economic and ethnic backgrounds express a yearning for parental attention and guidance. Fifteen years of research on all kinds of families confirm that a supportive family provides adolescents with powerful protection from engaging in high-risk and antisocial behaviors, especially when parents balance warmth and authoritativeness, give close supervision, and deal with conflict constructively.

Based on a large study of adolescents and their families, several conclusions emerge as to how families can nurture the growth of their adolescent members.[3] Perhaps most important is for parents to remain engaged with their adolescent children, to "hang in" rather than withdrawing, when young people act in ways that are maddening, as they often do. Also helpful is parents' willingness to disclose aspects of their own lives and perceptions, at the right moments and in ways that their teenage children can grasp. Many case histories suggest that adolescents benefit when parents are tolerant of new ideas and changes rather than being threatened by them.

To create a society more supportive of young people's development and well-being and to help teenagers and their families successfully navigate adolescence, strategies and opportunities in several areas need to be considered:

- Parents of preteens and teens need to know more about adolescent development and how to be effective in parenting adolescents. *Parenting education and family support* geared to this age group should be widely available. Additionally, special programs for parents are needed at times of crisis, such as pregnancy, substance abuse, or arrests. For their part, young people need to know more about parenting and its difficulties. Parenting education should begin in the early grades but is particularly important during the preteen and teenage years.

- A wide range of *community organizations and institutions*—cultural, recreational, religious, and youth organizations—should examine their current practices regarding the involvement of parents in appropriate activities with adolescents. At the national, state, and local levels, policies supporting community organizations that serve youth are among the most effective ways to help adolescents.

- *Workplace policies and practices* that enable families to spend more time with their adolescents are likely to increase opportunities for better parenting, family relationships, and outcomes for adolescents. Two-thirds of employed parents with children under 18 report a troubling shortage of time to spend with them.

- Arbitrary age cutoffs for *parental leave and child care tax credits* should be reexamined. Proposed legislation and policies should be informed by current knowledge about the importance of families during adolescence, especially from age 10 to 15.

- *Community infrastructure*, including community networks and factors contributing to neighborhood safety, can support or compromise the development of adolescents, therefore strengthening this infrastructure is key to helping adolescents.

Continuing the focus on meeting the needs of today's adolescents, Joy Dryfoos described the emergence of "full-service schools"—schools open to having provision in their buildings of an array of diverse services, typically brought in by outside health, social service, and youth agencies. This concept represents the fusion of several movements: improvement of adolescent health, school reform, and service integration for children and families. In 1991, Congress's Office of Technology Assessment (OTA) issued a report on the health status of adolescents, documenting the consequences of the "new morbidities"—sex, drugs, violence, depression—and calling for greatly expanded access to comprehensive health care. OTA declared school-based health clinics to be a very promising approach, serving as excellent access points for young people to primary health and social services. Such integrated access is particularly necessary because each of the "new morbidities" has its own funding stream and administrative location, and young people have a very difficult time accessing these fragmented, uncoordinated services.

The simplest model is the school-based clinic (SBC), a designated center within the school that delivers comprehensive health, mental health, and social services to the student body. Typically by contract, the provider is a local health department, community health center, medical facility, or youth-serving agency. Some centers, such as Kentucky's youth service centers (located in high schools with more than 20 percent free-lunch eligibility), focus on coordination and referral rather than on providing services in the schools.

Over the past decade SBCs have proliferated from 10 locations to nearly 700. The first models were in urban high schools; now they are being replicated in elementary and middle schools. In New York City, the youth agency created a version of full-service schools called Beacons. Community-based agencies receive support to develop these "lighted school houses," which are open from early morning until late at night, including weekends, throughout the year. They offer a wide range of activities, such as after-school recreation, educational remediation, community events, and health services, depending on neighborhood needs. Close cousins to the Beacons are "community schools," which seek to integrate quality education with support services, acting as village hubs. Open all hours and days, community schools have restructured academic programs integrated with parent involvement and services for

parents, health centers and family resource rooms, after-school activities, cultural and community activities. Such after-school activities and access to recreational facilities are especially important for adolescents, many of whom lack supervision and safe places to spend their time and tend to engage in high-risk behaviors in the hours after school.

Much of the available research on full-service schools has been on school-based clinics. One fact is clear: the demand for services is overwhelming. Located in the communities and schools with the greatest needs, school clinics are providing access to the highest risk students with the greatest number of problems and no other source of medical care. Where mental health personnel are available, substantial numbers of students and their families are participating in counseling as well. Most of those served have no other access to primary health care. As might be expected, use of emergency rooms has declined in areas with school clinics. With minor illnesses such as headaches and menstrual cramps being treated in school, absences and excuses to go home have decreased.

Large numbers of students are being diagnosed and treated for sexually transmitted diseases. Scattered evidence suggests that some school-based clinics have had an impact on delaying the initiation of sexual intercourse, upgrading contraceptive use, and lowering pregnancy rates, but only in programs that offer comprehensive family planning services. In some schools, clinic users have been found to have lower substance use, better school attendance, and lower dropout rates. Students, parents, teachers, and school personnel report a high level of satisfaction with school clinics.

Full-service schools cost from $75,000 a year for Kentucky's referral-oriented model to $800,000 for the most comprehensive community-school. School-based clinics average about $150,000 a year (not including large amounts of donated goods and services), or about $100 per year for each clinic user. States are major funders of these programs and, despite looming budget cuts, they are moving to support more comprehensive school-based models. Except for the initiative in the Bureau of Primary Health Care, no federal grants go directly to communities and schools for integrated services, but the full-service school concept has been recognized in significant new legislative endeavors, including Title I, the Crime Bill, and the new Empowerment Zone grants. Federal regulations could be changed to facilitate the increased use of categorical dollars for school-based centers. Medicaid already is being accessed in some schools, although providers experience difficulties with eligibility determination and reimbursement procedures.

Certain themes recurred across the three days of discussion and expert presentations. Participants noted the many ways that our society experiences the impact of children's receiving adequate or inadequate parenting. Likewise, society has much to lose or gain by the quality of child care that supplements parental care, especially for working parents.

Across the spectrum of promising interventions discussed throughout the conference, a common thread was the need for interventions to be of sufficient intensity, comprehensiveness, and duration to be effective. Small investments for one-shot or short-term interventions are often of little or no value. Assessments of successful interventions are beginning to reveal more about what it takes to get results.

The fact that comprehensive, sustained interventions are often needed to make lasting differences in people's lives raises a problem for large-scale replication of a program. Although the innovations and experience provided by small-scale, local programs will always be needed, widespread replication is not feasible in all cases. The most viable way to "scale-up" may be to change existing structures and institutions to incorporate lessons learned from the innovative programs, rather than trying to replicate the programs on a national basis.

Recognition of the need for life-long learning about child development and parenting was voiced in all three conference sessions. The years of middle school and early adolescence were identified as especially crucial for young people to learn about the responsibilities of parenthood (and thus the benefit of delaying pregnancy) and to acquire the knowledge and values that protect them from engaging in high-risk behaviors. To reduce teen pregnancy, unprotected sexual relations, substance abuse, possession of lethal weapons, and other risky behaviors, another priority is for young people to get consistent messages wherever they turn in the society—parents, school, outside organizations, and the media.

Finally, participants repeatedly expressed the view that policy makers must avoid "either-or"

thinking, that is, dichotomizing options as if a choice had to be made between one or another. For instance, strict law enforcement approaches do not need to preclude implementing strong preventive methods. Stressing abstinence for young adolescents is not incompatible with teaching them about contraception. Enforcement of child support need not undermine positive attempts to involve young men in the lives of their children. In many cases, the best approach may be to combine strategies rather than choose between them.

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The Challenge of Parenthood

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The poet E. E. Cummings wrote, "It takes three to make a child." I take this to mean a baby plus two parents or at any rate two responsible caring adults. It is a very big job, a huge investment of time, energy, and sustained attention; and a great learning experience for all three. But the process is far from simple—and now more complicated than ever.

Some of the dilemmas cut across our entire society: rich, poor, and in-between. By and large, young people moving toward parenthood have less experience caring for children than any of their predecessors had. Moreover, they face more rapidly changing circumstances and a wider spectrum of life choices. But choices and decisions and transitions can be burdens, even as they offer attractive opportunities and privileges. A young couple today often agonizes over decisions taken for granted even a generation ago. Should they get married? If yes, should they wait until one or both has a steady job, until after college, or graduate school, or postgraduate work? Where should they live? What about the fateful decision to have children?

Once married, since it is very likely that both husband and wife are in the paid labor force, they will have to renegotiate their relationship with the advent of the baby. How will they divide the baby-care chores? What sort of parental leave, if any, will each take? What kind of flexibility can they build into their schedules? How will they handle the housework? How can they balance work and family life? If the mother takes off from work for a while, when is it sensible to go back, and how can she best make the transition? Can they afford quality child care? At what point is it safe to bring the baby to a day-care center? How will they recognize high-quality child care when they find it? When the child is ready for preschool education, should it be geared toward play or be strongly academic? When the time comes for school, should it be public or private?

University of California sociologist Arlie Hochschild, coauthor of *The Second Shift: Working Parents and the Revolution of Home*, conducted systematic research that illuminates the tension between work and family. She describes the cost women pay whether they choose to concentrate on working at home or on having a paid career. The housewife pays the cost of remaining outside what is today the mainstream of society. The career woman pays the cost of the drain of time and energy from family commitments. Many creative efforts to synthesize these roles are now being explored.

The research evidence clearly indicates that husbands share very little of the burden of raising their children and caring for their homes. Hence, many women are coming home from a paid job and working a "second shift." Most men devote long hours to their work. Even if they want to be helpful at home, their institutional settings usually do not make it easy for them to do so. How is it possible to create flexible work schedules and a supportive community for joint parenting?

The role of the family as the fundamental unit responsible for the health, education, and general well-being of children is crucial. Whatever has hap-

pened to it, it is still the central organizing principle of society. But families do not function in isolation. They need an appropriate social environment to be successful. This means a supportive social network, the ability to make a living, a firm sense of community and belonging. In one way or another, all families need help today, and disadvantaged families desperately so. Families differ greatly in their material resources and their cultural traditions. Most are resilient in the face of adversity. But unless basic family needs are met, our children are at risk of poor outcomes.

There have been dramatic changes in the structure and function of American families in just a few decades. Some of these changes represent new opportunities and tangible benefits. Others represent serious jeopardy to the well-being of children—on a large enough scale to pose a major problem for the entire society. Perhaps the most striking change from the perspective of child development is the rapidity of entry of mothers of young children into the work force. By 1990, more than half of all mothers of young children, preschool as well as school aged, held jobs outside the home—and found it difficult to integrate work and family responsibilities. Today most American children spend part of their childhood in a single-parent family. By age sixteen, close to half of the children of married parents see their parents divorce. Moreover, as compared with other countries, America exhibits a kind of revolving-door pattern of repeated marriages and divorces, of multiple attachments and disruptions, that is certainly stressful for developing children and adolescents.

The total time parents spend with their children has diminished by about one-third in the past thirty years. Not only are children's mothers home much less, but there is very little evidence that fathers spend more time at home to compensate. Moreover, only about five percent of American children see a grandparent regularly.

With all the radical shifts in family life, it is not surprising that surveys of public opinion indicate that American parents are troubled about raising their children. Parents report deep concern about serious problems: educational failure; delinquency; suicide; adolescent pregnancy at increasingly early ages; fatal accidents and homicides; and sexually transmitted diseases. And they worry about a broad trend toward the decreasing commitment of parents to their children. Two-thirds of them report that they are less willing to make sacrifices for their children than their own parents would have been.

Many indices show that the United States is suffering heavy casualties during the years of growth and development—in educational failure, poor health, and very high-risk behavior. Generally, these casualty rates are considerably higher than those of other technically advanced democracies. With all the drastic changes in family life and other circumstances of jeopardy, it is necessary to find ways to strengthen the conditions for healthy child development. We must draw on research evidence and carefully assessed innovations to find out what is feasible now. For instance, community-based early interventions to strengthen families have been developed and tested in recent decades. They serve a variety of purposes: to augment parents' knowledge and skill in child rearing; enhance their ability to cope with the vicissitudes of child development and family relations; help families gain access to health, educational and social services; facilitate informal support networks among parents; and organize to counteract dangerous trends in the community—e.g., drugs. Such efforts provide emotional encouragement, cognitive stimulation, and social support. They build parental competence and can be useful to two generations—helping young parents and their children on a long-term basis.

Within the scientific and professional communities, a remarkable consensus is emerging on the conditions that influence child and adolescent development—and how parents can cope with all the changes in a competent way. Much has become known about ways to prevent the damage being done to children. It is crucial now to have well-informed, wide-ranging public discussion so that constructive decisions can be made by individual families and by policymakers. No single approach to families and children can be a panacea; many approaches are needed to span the main years of growth and development during early childhood, continuing through middle childhood and into adolescence.

During their years of growth and development, children need dependable attachment, protection, guidance, stimulation, nurturance, and ways of coping with adversity. Infants, in particular, need caregivers who can promote attachment and thereby form

the fundamental basis for decent human relationships throughout the child's whole life. Similarly, early adolescents need to connect with people who can facilitate their momentous transition to adulthood gradually, with sensitivity and understanding. Usually, despite the radical transformations of recent times, such people are within the child's immediate family; if not, they exist to some extent in the extended family. But if these caregivers cannot provide the necessary conditions for healthy development, then others must make an explicit effort to connect children with persons outside the family who have the right attributes and also the durability to do so. In this meeting, we can consider approaches based on the latest research that provide a genuine basis for hope, even on the toughest problems.

The first few years of life provide the opportunity for a decent start. Such a beginning greatly increases the odds of lifelong learning, the acquisition of constructive skills, good health, and the development of valued human attributes including prosocial behavior. In short, the time from conception through the third year has a great bearing on physical, cognitive, emotional, and social development—for better or worse.

If a poor start leaves an enduring legacy of impairment, then high costs follow. They may show up in various systems: health, education, justice. We call them by many names: disease, disability, ignorance, incompetence, hatred, violence. By whatever name, these outcomes involve severe economic and social penalties for the entire society. This is why Carnegie set up a distinguished task force to study the years from zero to three and the findings were presented in a 1994 report called *Starting Points.*

This task force clarified the scientific-professional consensus and brought the latest information to bear on our youngest children and their families. Its view took account of all our children, with special attention to children in poverty. Its ultimate recommendations had four main thrusts.

1. Preparation for responsible parenthood, from education in the life sciences during early adolescence to pervasive opportunities for substantial parent education (in conjunction with prenatal care, primary health care, child care centers, and Head Start).

2. Health care. Comprehensive prenatal and primary health care with concomitant educational and social services, including opportunities for early home visits.

3. Child care. For example, cooperative networks and training to strengthen the quality of child care; wider use of the Head Start model that combines parental involvement with disease prevention and stimulation of cognitive as well as social skills.

4. Community mobilization.
   a) Family-child resource centers
   b) Federal, state, local councils: built on intersectoral cooperation
   c) Service integration, e.g., at community, full-service schools
   d) Business participation
   e) Media participation

It is worth emphasizing the importance of pervasive opportunities for parent education. Historically, these have mainly been in the family of origin during the years of growth and development—for example, through supervised care of younger siblings. In view of the drastic family dislocations of recent decades, it is useful to fill the gaps in preparation for parenthood by making such opportunities readily available in close relation to prenatal care, primary health care, child care facilities and Head Start.

The need is for substantial, in-depth parent education including supervised practice in responsible child care. This includes: information about child development and child health; constructive and hopeful attitudes toward child-rearing; fostering close relationships between parents and child; illuminating the joy in child development as well as pride in the stamina of competent parenting; learning ways of coping with foreseeable transitions; learning how to find and use community resources for child development; learning how to seek, accept and give help—especially in mutual aid among parents. All this can be done effectively even in poor communities as the experience of AVANCE will show in this meeting.

CONCLUDING COMMENT

Overall, meeting the essential requirements for healthy child development in the first few years of life is a vital national problem. It is not primarily a federal problem, though there is a federal role. All major sectors are needed. A division of labor will have to be sorted out through democratic processes.

The problems are difficult. We are in the midst of a wrenching transformation. We must not let the perfect become the enemy of the good. The central question is whether we can do better than we are doing now. The social and economic costs of severely damaging conditions that distort growth and development are terrible not only in the intrinsic tragedies of these shattered lives but also in effects that hit the entire society, rich and poor alike—the costs of disease and disability, ignorance and incompetence, crime and violence, alienation and hatred. These are infections that know no boundaries, that cannot be effectively contained unless they are prevented in the first place.

I like to think that powerful sectors have begun to converge on the problems of children: business, government, clergy, media, science and several professions including the military. If a broad public consensus emerges on the facts, multi-sectoral leadership continues to grow, and constructive policy options are fully considered, we could see a real transformation in the health and well-being of all our children.

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Preparation for Parenthood

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INTRODUCTION

Forming families and bearing children—becoming parents—is among the most important tasks of adult life, often joyful, sometimes stressful, always time-consuming and tiring. But in recent years, in America, there has been a growing sense that all is not well with the profession and discipline of parenthood. We worry, collectively, about who is raising our children in this era of dual earner families; we worry about the capacity of busy parents to guide their children through the land mines that surround them—alcohol and substance abuse, precocious sexual activity, violence and fear for the future; and we worry, too, about how best to prepare them for a world in which, increasingly, the experience of parents is often irrelevant to the tasks that children need to master.

Learning how "to parent" is a chore that takes years to accomplish, beginning most importantly with a child's careful observations about his or her own parents. Other institutions—religious and community groups, the extended family and neighborhood, and both the media and formal schooling—offer additional perspectives on parenting to supplement these early lessons.

But it is important to recognize two additional forces that can affect the ability of parents to do their job well: first, the extent to which pregnancy (and thus parenting) is actively planned and intended; and second, the extent to which the prenatal period is used to bolster confidence, develop specific parenting skills, and build bridges to the next life stage—infancy and toddlerhood.

INTENDED PREGNANCY

For all of us with a special interest in child well-being and parenting, it is important to reflect on the relevant policy issues that have consumed our attention over the last ten to fifteen years. Admittedly, one of the most salutary developments of the late 1980s and early 1990s was the growing emphasis on children as a precious national resource and an important policy priority. In the face of limited budgets and competing demands, many states and the federal government found numerous ways over the last decade to direct money and attention to children—expanding eligibility for Medicaid in order to finance health care for low-income children and pregnant women, increasing authorizations for the popular Head Start program, and stimulating programs in virtually every state to address infant mortality and early childhood immunization, improve the quality of education in America, offer early intervention services for at-risk families, reach pregnant women with prenatal care, and use school settings in new ways to provide a wide variety of human services.

Interestingly, none of these initiatives come into play until a pregnancy is underway or a child is in our arms. Less attention—actually, almost none at all—has been directed to the notion that encourag-

ing wanted, intended pregnancy might be one way to strengthen the lives and well-being of children and their parents and families. In fact, pregnancy prevention and family planning have generally been treated as marginal or "controversial" activities, rarely discussed in a broad, comprehensive way that recognizes the important role that fertility control plays in the lives of men and women, in child well-being, and in the overall tenor of communities. In particular, pregnancy planning has not been included as a central, routine component of health and social services, especially preventive health care and education.

As evidence of this neglect, public investment in family planning services declined during the 1980s, perhaps by as much as a third. In particular, federal outlays for family planning through the so-called "Title X" program (that portion of the Public Health Service Act that provides grants to various state and local entities to offer family planning services to low-income women and adolescents) dropped precipitously during the 1980s in the face of higher costs and sicker patients, which probably decreased access to care for those who depend on publicly-financed services. Although increased commitments from other public and private sources helped to fill a portion of the gap, field reports from around the country confirm that access to contraception is often limited. Similarly, through a combination of financial and structural factors, the health care system in America often makes access to contraception a complicated, sometimes expensive proposition. Private health insurance often does not cover contraceptive costs; the various restrictions on Medicaid eligibility make it an unreliable source of steady financing for contraception except for the poorest women; and because the best forms of contraception require contact with a physician, all of the bureaucratic and systemic problems that plague the health care system generally also limit access to birth control in particular.

The consequences of unintended pregnancy are serious, imposing appreciable burdens on children and their parents. A woman with an unintended pregnancy is less likely to seek early prenatal care and is more likely to expose the fetus to noxious substances (for example, by smoking). The child of an *unwanted* conception especially (as distinct from a mistimed one) is at greater risk of being born at low birthweight, of dying in its first year of life, of being abused, and of not obtaining sufficient resources for healthy development. The mother may be at greater risk of depression and of physical abuse herself, and her relationship with her partner is at greater risk of dissolution. Both mother and father may suffer economic hardship and fail to achieve their educational and career goals.

In addition, an unintended pregnancy increases the probability of a child being born to a mother who is adolescent, unmarried, or over 40—demographic attributes which themselves have important socioeconomic and medical consequences for both children and parents. Pregnancy begun without planning and intent also means that individual women and couples are not able to take full advantage of the growing field of preconception risk identification and management, nor the rapidly expanding knowledge regarding human genetics. Moreover, unintended pregnancy currently leads to approximately 1.5 million abortions in the United States annually, a ratio of about one abortion to every three live births. This ratio is two to four times higher than that of other industrialized countries.

About 60 percent of all pregnancies in the United States are unintended; half of these are resolved by abortion. During the 1970s and early 1980s, a decreasing proportion of *births* were unintended at time of conception. Between 1982 and 1988, however, this trend reversed and the proportion of births that were unintended at conception began *increasing*. This unfortunate trend appears to be continuing into the 1990s.

The extent and consequences of unintended pregnancy are poorly appreciated throughout America. Although considerable attention is now focused on teenage pregnancy and illegitimate childbearing, and violent controversy over abortion escalates, the common link among all these issues—pregnancy that is unintended at the time of conception—is essentially invisible. As a consequence, most proposed remedies ignore the common underlying cause or address only one aspect of the problem, and a few vulnerable groups (such as young unmarried women on welfare) are subjected to special scorn.

Reducing unintended pregnancy may well require a public-private, multifaceted and long-term effort (much like the anti-smoking campaign) to:

(a) improve knowledge about contraception, unintended pregnancy, and reproductive health generally;

(b) increase access to contraception;

(c) explicitly address the major role that motivation plays in using contraception and avoiding unintended pregnancy;

(d) develop and scrupulously evaluate a variety of local programs to reduce unintended pregnancy; and

(e) fund research to develop new contraceptive methods and to answer important questions about how to organize and support contraceptive services.

Because unintended pregnancy is a widespread problem, all of these efforts will need to target men as well as women, and older individuals as well as teenagers. Too few people understand that it is not only teenagers who become pregnant unintentionally or that involving men in the issue of pregnancy prevention will be central to the success of any remedial effort.

Reducing unintended pregnancy will ease many contemporary problems that are of great concern. Both teenage and nonmarital childbearing would decline, and abortion in particular would be reduced dramatically. At the same time, however, it is important to help the public understand that even if it were possible to eliminate all unintended pregnancy among both teenagers and unmarried women, there would continue to be large numbers of such pregnancies, because it is not only these groups who contribute to the pool. For example, of all births from 1986 to 1988 that were unintended at conception, only 21 percent were to teenagers.

PRENATAL OPPORTUNITIES

Although the issue of pregnancy prevention may not have fared well in recent years, there has been a gratifying upsurge of attention to the prenatal interval. These few months are increasingly recognized as a "teachable moment," par excellence, during which unique opportunities exist for education, support and future planning.

Over the last 10 years especially, there has been a growing understanding that prenatal care improves the lives of children and women, and that we need to improve access to this key service. Virtually every state in the union has organized some sort of initiative to increase participation in prenatal care; the eligibility of pregnant women for the Medicaid program was expanded steadily in the 1980s, and many states, such as North Carolina, have been creative in leveraging Medicaid dollars to finance programs that go well beyond rudimentary medical care, adding case management, ancillary services and various social supports especially for high-risk women.

The benefits of prenatal care have been repeatedly documented: women who receive the full course of such care are more likely to deliver a full term infant of adequate weight than women who receive insufficient care. Infants born at low birthweight (less than 5½ pounds) are significantly more likely to have neurodevelopmental handicaps than those born at adequate weight; for example, centers that follow low birthweight infants report rates of learning disabilities running as high as 40 to 45 percent, and the smaller the infant at birth, the higher the likelihood of long-term problems. Further, low birthweight and premature infants are more likely to have congenital anomalies and more frequent respiratory tract infections; over 40 percent of these infants are rehospitalized more than once in their first year of life.

A key point of consensus is that the effectiveness of prenatal care hinges on its comprehensiveness and its ability to match interventions to risks. The conventional model of prenatal care for years was to concentrate only on medical risks, especially those that develop in the last weeks of pregnancy—thus the schedule of visits which concentrates most care just before labor and delivery. More recently, prenatal care has expanded to address such behavioral issues as smoking, poor nutrition and stress.

In the very best prenatal care, pregnant women and their partners are also offered education about parenting to supplement and support what they have already learned from their own families and life experiences—what newborns need to grow and thrive, how to bathe and feed an infant (emphasizing breast feeding), how to recognize illness in infants

and young children, how to help young children regulate their patterns of eating and sleeping, what to do about persistent crying, where to go for help and who to call when the challenges of parenting become overwhelming. Those who care for pregnant women and their partners point out that beginning to educate parents about these issues *during* pregnancy is often more successful than waiting until after a child is born, or until after a problem is manifest. Prenatal care is thus increasingly seen as an interval during which education for parenting should accompany more conventional (and important) attention to various medical risks.

Despite the overwhelming consensus that prenatal care strengthens parents and improves the chances of delivering a healthy baby, thousands of children are born each year whose mothers have had little or no prenatal care. In 1990, for example, about one fourth of pregnant women did not receive adequate prenatal care, and the number of women who receive virtually no care at all is *increasing*.

This discouraging picture may well be related to unintended pregnancy. Not surprisingly, women with unintended pregnancies tend to obtain prenatal care later then those with intended pregnancies. Women who do not expect to conceive may be less aware of the signs and symptoms of pregnancy and therefore may recognize pregnancy later; those who view their pregnancy negatively may delay prenatal care while deciding whether to seek an abortion; and an unplanned pregnancy is likely to evoke ambivalent feelings that may result in late or sporadic care. Here again are clear links among contraception, intended pregnancy, early enrollment in prenatal care and child well-being.

CONCLUSION

In sum, parenting is enhanced and supported by both intended pregnancy and prenatal care. Nonetheless, the United States displays high rates of both unintended pregnancy and of late registration for prenatal care. Although much attention has been given in recent years to increasing the percentage of women who begin prenatal care early in pregnancy, little attention has been given to reducing unintended pregnancy. It may well be that participation in prenatal care will remain poor until more pregnancies are consciously and willfully undertaken.

Promising Preventive Interventions During Pregnancy, Infancy, and Early Childhood

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Many of the most pervasive, intractable, and costly problems faced by young children and parents in our society today are a consequence of adverse maternal health-related behaviors (such as cigarette smoking, drinking and drug use) during pregnancy, dysfunctional infant caregiving, and stressful environmental conditions that interfere with parental and family functioning. These problems include infant mortality, preterm delivery and low birthweight, child abuse and neglect, childhood injuries, youth violence, closely spaced pregnancy, and reduced economic self-sufficiency on the part of parents. Fortunately, evidence is accumulating that these problems can be reduced with comprehensively designed programs that support mothers' efforts to care for themselves during pregnancy and parents' efforts to care for their children and for themselves in the early years of the child's life.

SCOPE OF THE PROBLEM

Standard indices of child health and well-being indicate that many children in our society are suffering.

- Nine infants out of every thousand in the United States die before their first birthday. Our infant mortality rate is worse than 19 other nations, in spite of dramatic reductions in infant mortality in the last two decades due to improvements in newborn intensive care. Thirty to 40 percent of very low birthweight babies (less than 1,500 grams) who are saved by newborn intensive care eventually will exhibit some form of developmental disability. Further reductions in infant mortality will require significant reductions in our excessive rates of preterm delivery and low birthweight (less than 2,500 grams).

- Over 2.9 million children were reported as being abused or neglected in 1992 and one in three of the victims of physical abuse were infants less than one year of age. Between 1,200 and 1,500 children die each year as a result of parent or caregiver maltreatment. Not only is maltreatment morally unacceptable, but the social consequences are so devastating that the U.S. Advisory Panel on Child Abuse and Neglect has called child maltreatment a national emergency.

- Childhood injuries are the leading cause of death among children aged one through 14.

- High rates of violence among adolescents, both as victims and perpetrators, threaten the safety and well-being of our neighborhoods. Among young people aged 15–24, homicide is the leading cause of death, and for African Americans it is number one.

While these problems cut across all segments of U.S. society, they are more common among children born to poor, teenaged and single parents, and among women who have rapid, successive pregnancies. A significant portion of these problems can be traced to parental behavior—in particular to women's health-related behaviors during pregnancy and to the qualities of care that parents provide to their children. Low-income, single, adolescent mothers can have good pregnancy outcomes and children who do well, if they are able to care for themselves and for their children. Their capacity to do so, however, is often compromised by histories of maltreatment in their own childhoods, psychological immaturity or depression, stressful living conditions, and inadequate social support. These conditions contribute to the greater likelihood that socially disadvantaged parents will abuse cigarettes and other drugs during pregnancy and will fail to provide adequate care for their children, often with devastating results.

Women who smoke cigarettes and use other substances during pregnancy, for example, are at considerable risk for bearing low birthweight newborns; and their children are at heightened risk for neurodevelopmental impairment. Even subtle damage to the fetal brain can have devastating effects on children's intellectual functioning and capacity for emotional and behavioral regulation. Parents' capacities to read and respond to their infants' communicative signals form the basis for children's sense of security and trust in the world and their belief in their capacity to influence that world. Breaches of that trust have long-term consequences, especially when caregiving dysfunction is combined with neurodevelopmental impairment on the part of the child.

A recently reported longitudinal study of a large Danish sample of children and their families found that children who experienced the combination of birth complications and parental rejection in the first year of life were at substantially increased risk for violent criminality at age 18 in comparison to children who experienced only birth complications or parental rejection alone. While only 4.5 percent of the sample experienced both birth complications and parental rejection, that group accounted for 18 percent of all violent crimes among the 18 year olds. When risk factors accumulate, the risk for adverse outcomes increases, often in synergistically vicious ways.

PROMISING PROGRAMS

While the problems listed at the beginning of this paper have been resistive to government intervention over the past 30 years, scientific evidence is accumulating that it is possible to improve the outcomes of pregnancy, to improve parents' abilities to care for their children, and to reduce welfare dependence—but it is not easy. Our optimism stands in contrast to earlier research on programs to prevent these problems. The earlier research was difficult to interpret because the studies frequently suffered from one of two problems—either the programs studied were not designed to address the needs of parents in sensible and powerful ways, or the research itself lacked scientific rigor. Within the past eight years, however, a new wave of preventive intervention research has studied programs that are programmatically powerful and has employed research methods that are scientifically rigorous. The results are encouraging. In the following sections, we review two illustrative, promising preventive intervention programs and consider the lessons that can be learned from these studies about what it might take to produce a significant improvement in the health and development of children from low-income, at-risk families.

The Polly T. McCabe School-Based Program for Pregnant Adolescents

Recent evidence from a study of an intensive school-based program for young mothers and their babies in New Haven, Connecticut is encouraging. It is designed for pregnant students who otherwise might drop out of school. Students are referred to the school from their regular schools when their pregnancy becomes apparent; they typically remain at McCabe for the academic quarter during which they deliver their baby and then return to their regular school the following quarter. The program offers small classes, individually paced instruction, personal guidance, and mentoring from teachers, nurses, and social workers. During pregnancy, the students are under the supervision of nurses for five days a week. The close supervision of the nurses supplements routine prenatal care. The program also helps students plan for self sufficiency, including delaying subsequent pregnancy. The program has improved the outcomes of preg-

nancy and reduced many of the most significant risks for welfare dependence.

The evaluators of this program were remarkably innovative in estimating the impact of the program by exploiting the fact that pregnant students receive McCabe services at different stages in gestation and for different lengths of time after delivery because of differences in the start of gestation and the start and end of the school year. They found that those students who received services early in gestation had much lower rates of preterm delivery and low birthweight than those who received services later in gestation. One percent of the students who participated in the program during the first half of their pregnancies delivered a preterm baby as opposed to 12 percent of the students who participated in the program during the last half of gestation. After delivery, students who remained in the program seven weeks or longer were able to delay subsequent childbearing substantially more than those who dropped out of the program at earlier stages. During a two-year period after delivery of their first child, mothers who stayed in the program for seven weeks or more were three times less likely to deliver a new child than their shorter-stay counterparts; and during a five-year period after birth of the first child, 70 percent of the short-stay mothers had delivered one or more children, compared to 45 percent of those who had remained in the program seven weeks or more. Moreover, among mothers who exhibited poor academic performance prior to becoming pregnant, those who had longer exposure to the McCabe program made greater improvements in their academic standing during a two-year period after leaving McCabe.

Home Visitation by Nurses

Another promising approach is home-visiting by nurses during pregnancy and the early years of the child's life. My colleagues and I have carried out two large-scale randomized trials of prenatal and early childhood home visitation services, with two very different populations in two very different settings (Elmira, New York and Memphis, Tennessee), that suggest that it is possible to reduce the rates of poor pregnancy outcomes and caregiving dysfunction, and to reduce the risks for welfare dependence and youth violence among low-income families.

Elmira Study. Starting in 1977, we carried out a study of comprehensive prenatal and postpartum nurse home visitation in and around Elmira, New York. We enrolled 400 women before the 30th week of pregnancy, 85 percent of whom were either low-income, unmarried, or teenaged. None had a previous live birth. Eighty-nine percent of the sample was Caucasian. The findings reported below apply to the Caucasians. We randomly assigned the participating women to receive either home visits by nurses (from pregnancy through the child's second year of life) or to comparison services (transportation for health care and screening for health problems).

- *Home-Visitation Program.* The home-visitation program was designed to improve three aspects of maternal and child functioning: 1) the outcomes of pregnancy; 2) qualities of parental caregiving (including reducing associated child health and developmental problems); and 3) maternal life-course development (helping women return to school, find work, and plan future pregnancies). The nurses completed an average of 8 visits during pregnancy and 25 visits from birth through the second year of the child's life.

- *Prenatal Findings.* Compared to their counterparts, during pregnancy nurse-visited women improved the quality of their diets to a greater extent and those identified as smokers at the beginning of pregnancy smoked 25 percent fewer cigarettes by the end of pregnancy. By the end of pregnancy, nurse-visited women had fewer kidney infections, experienced greater informal social support, and made better use of formal community services. Among women who smoked, those who were nurse-visited had 75 percent fewer preterm deliveries; and among very young adolescents (aged 14–16), those who were nurse-visited had babies who were nearly 400 grams heavier, in contrast to their counterparts assigned to the comparison group.

- *Infancy and Early Childhood Findings.* During the first two years after delivery, according to state records, 19 percent of the poor, unmarried teens in the comparison group

abused or neglected their children as opposed to 4 percent of the poor, unmarried teens visited by a nurse. This result was corroborated by independent observations of maternal-child interaction and conditions in the home, and medical records. It is important to note that the impact of the program on child maltreatment was further moderated by the women's sense of control over their life circumstances when they registered in the program during pregnancy. For poor, unmarried teenagers in the comparison group, as their sense of control declined, the rates of child maltreatment increased substantially in the comparison group, but not in the nurse-visited group. We found the same pattern of results for emergency-department encounters for injuries and ingestions during the second year of the children's lives (when they first become mobile and are at greater risk for injury). As with maltreatment, emergency department encounters increased as the comparison-group women's sense of control declined, but did not in the nurse-visited group. Based on these findings, we hypothesized a similar pattern of results in our Memphis study (reported below), but reasoned that a broader range of psychological characteristics (intelligence, mental health, and coping capacity) would moderate program effects on the rates of child maltreatment and injury.

In addition, between their 24th and 48th month of life the children of nurse-visited women were 40 percent less likely to visit a physician for an injury or ingestion than were their comparison-group counterparts.

During the 4-year period after delivery of the first child, among low-income, unmarried women, the rate of subsequent pregnancy was reduced by 42 percent, and the number of months that nurse-visited women participated in the work-force was increased by 83 percent. (In order to fully interpret the findings from the Memphis study that we report below, it is important to note that by the children's second year of life, the rate of subsequent pregnancy in Elmira was reduced by 33 percent.) Moreover, much of the impact of the program on work-force participation among the adolescent portion of the sample did not occur until the two-year period after the program ended, when the teens were old enough to obtain jobs. In addition, children born to nurse-visited women who smoked 10 or more cigarettes when they registered in the program had IQ scores at three and four years of age that were four to five points higher than did their counterparts in the comparison group. This is because children born to comparison-group women who smoked 10 or more cigarettes during pregnancy showed a decline in intellectual functioning over the first four years of life that we think is due to neurodevelopmental impairment resulting from prenatal exposure to the adverse effects of cigarettes. The protective effect of the program was most likely due to the nurse-visited women's reduction in cigarette smoking and improvement in quality of diet during pregnancy.

- *Cost Analysis Through Age Four.* We examined the impact of the program on families' use (and corresponding cost) of other government services. In 1980 dollars, the program cost $3,173 for two and half years of intervention. We conceived of government savings as the difference in government spending for these other services between the group that received home visitation and the comparison group. Savings were expressed in 1980 dollars and were adjusted using a three-percent discount rate. By the time the children were four years of age, low-income families who received a nurse during pregnancy and through the second year of the child's life cost the government $3,313 less than did their counterparts in the comparison group. When focused on low-income families, the investment in the service was recovered with a dividend of about $180 per family within two years after the program ended.

Memphis Study. The Memphis trial was designed to find out whether the promising effects of the Elmira program could be replicated with a large

sample of low-income, African-American families living in a major urban area, and when the program was carried out through an existing health department. One thousand one hundred and thirty-nine women less than 29 weeks pregnant were recruited from the obstetrical clinic at the Regional Medical Center in Memphis, Tennessee. Ninety-two percent of the women were African American, 97 percent were unmarried, 65 percent were aged 18 or younger at registration, 85 percent came from households with incomes at or below the federal poverty guidelines, and 22 percent smoked cigarettes at registration. These women were randomized to receive home-visitation or comparison services (transportation for prenatal care and developmental screening for the children).

- *Program Plan and Implementation.* The experimental home-visitation program was carried out by the Memphis/Shelby County Health Department and was modeled after the program carried out in Elmira. During pregnancy, the nurses helped the women monitor their diets and weight gain. They assessed women's cigarette smoking, use of alcohol and illicit drugs, and facilitated a reduction in substance abuse with the establishment of small, achievable objectives for behavioral change between visits. The nurses taught women to identify the signs and symptoms of pregnancy complications, encouraged women to inform the office-based staff about those conditions, and facilitated compliance with treatment. They gave particular attention to urinary tract infections, sexually transmitted diseases, and hypertensive disorders.

  After delivery the nurses used a detailed curriculum to help mothers and other family members manage the physical and emotional challenges of caregiving, to help women set goals for themselves, and to help women carry out their plans for completing their educations, finding work, and planning future pregnancies.

  The nurses completed an average of 8 home visits during pregnancy and 25 visits during the first two years of the babies' lives, exactly the same number of completed home visits as we observed in Elmira.

- *Prenatal Findings.* In contrast to women assigned to the comparison group, at the end of pregnancy nurse-visited women reported smoking 26 percent fewer cigarettes, 46 percent less alcohol consumption; nurse-visited women were 58 percent more likely to use other community services, had 24 percent fewer cases of pregnancy-induced hypertension (PIH—a serious complication of pregnancy), and those women with PIH had less severe cases.

- *Infancy Findings.* Throughout the first two years of the child's life, in contrast to women assigned to the comparison group, nurse-visited women reported fewer beliefs associated with child abuse (lack of empathy for children and a belief in physical punishment as a means of disciplining infants and toddlers); and the homes of nurse-visited women were rated as more conducive to children's development. Moreover, nurse-visited women reported more frequent breastfeeding during the first six months of the child's life (21 percent versus 13 percent). Children born to mothers with limited psychological resources (lower intelligence, higher levels of mental health symptoms, and a less active coping style) were observed to be more responsive to their mothers and to communicate their needs more clearly than did children born to limited-resource mothers in the comparison group, an effect we have interpreted as a reflection of the nurse-visited infants having mothers who were more sensitive and responsive to their needs and less intrusive and hostile.

  This interpretation of the positive effects of the program on the behavior of children born to low-resource mothers is reinforced by the impact of the program on children's health-care encounters for injuries and ingestions. During the first 2 years postpartum, children born to nurse-visited mothers with limited psychological resources had 37 percent fewer encounters with the health care system for injuries and ingestions than did their counterparts in the comparison group, following a pattern that was remarkably similar to what we observed in Elmira

for mothers with limited sense of control over their lives.

By the end of the Memphis program at the child's second birthday, nurse-visited women reported substantially greater sense of control over their lives, 26 percent fewer second pregnancies, and 20 percent greater household incomes than did women who had been randomly assigned to the comparison group. Nurse-visited women with high levels of psychological resources reported 29 percent less AFDC enrollment during the second year of the child's life (about 2 months less) than did high-resource mothers in the comparison group.

Other Trials of Home-Visitation. We recently reviewed all of the other randomized trials of pregnancy and infancy home visitation programs aimed at preventing health and developmental problems in pregnant women and children. Our review shows that programs vary tremendously in terms of their objectives, target populations, structure, the background of the visitors, and their corresponding effectiveness. Some home-visitation programs simply do not work. The more successful programs focused their services on families in greater need for the service, used nurses who visited frequently beginning during pregnancy and who continued at least through the second year of the child's life. Visitors in the more successful programs were well trained to promote positive health-related behaviors and qualities of infant caregiving, and to reduce family stress by improving the social and physical environments in which families live. Programs that had none or only one of these characteristics were unable to produce the desired effect. The interpersonal and contextual conditions that such programs must address are often highly complex and difficult to change, but if such programs are designed to address important family needs in thoughtful and systematic ways, home-visiting programs can make important changes for a significant portion of the families in greatest need.

CONCLUSIONS

Whether we look at school-based programs for adolescent parents or home-visiting programs for pregnant women and parents of young children, the evidence indicates that it is possible to improve the outcomes of pregnancy and early childrearing and to reduce the risks for welfare dependence, conduct disorder, and violence if the programs are comprehensive, intensive, and long-lasting. While the types of programs described here are expensive, preliminary data indicate that the long-term costs of failing to provide these services exceed the initial investment in the service. Even though the evidence on these types of preventive interventions is still accumulating, we know today a great deal more about how to effectively address these problems than we did as recently as five years ago. Our next challenge is to understand how to scale up these programs to be carried out in many more settings while preserving the vitality of the original models.

On Building Parental Competence: The Nature of Contracts and Commitments

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INTRODUCTION

Much public debate today focuses on the nature of America's social contract with its families, particularly with regard to the timing, intensity, and financing of support for the poor, infirm, and disabled. A second and more basic contract—the familial contract made between parents and their offspring—has received far less policy attention, as have efforts to enhance it. In considering how to support perhaps the most critical of all contracts—the familial contract—this paper focuses on an array of parent education efforts. In the first section below, I suggest that according greater policy attention to parent education and support is: (a) fully compatible with our historic traditions and intentions in assisting families; (b) increasingly necessary; and (c) timely and doable, particularly given the emergence of new knowledge, codified principles, and notable program approaches. In the second section, I suggest specific issues and strategies that might be considered as the nation addresses familial and social commitments to children via parent education and support.

PARENT EDUCATION AND SUPPORT: ADDRESSING FAMILIAL AND SOCIAL COMMITMENTS

Parent Education: Historic Traditions and Intentions

Parenting education and support is not a new fad or phenomenon on the American familial landscape. Informally, parent education has existed since the beginning of civilization, with new parents innately mirroring behaviors of, and seeking guidance from, caring adults. Each period of history and each culture differs in the beliefs and "lessons" to be transmitted. In colonial and early America, for example, principles of child rearing were based on the moral rectitude of religious beliefs; the church acted as a major source of parent education, reinforced by time honored daily contact among relatives, friends, and all-knowing neighbors (Weissbourd, 1987). As the nation matured, more formal commitments to parent education took hold via the emergence, in the early 1800s, of mothers' associations that were designed as study groups to discover ways to "break the will of the child" (Schlossman, 1978). Later, at the turn of the century, groups that had formed largely to discuss parental concerns banded together to create the National Congress of Mothers which, in turn, became the PTA. The PTA favored parents' perspectives on child rearing,

though it regarded the emerging science of child development with keen interest. The science of child development and the child study movement, however, remained fairly aloof from the PTA, linking instead with the Federation for Child Study. Though separate, both the PTA and the child study movement did much to further parent education; both saw knowledge as the key to improving the lives of children and worked to assure that children would be understood as organisms independent of and dependent upon the social context.

Simultaneous to the emergence of a theoretical tradition, and fueled by massive demographic alterations—urbanization, immigration, and industrialization—concern about poor and "failing" families escalated at the end of the last century. Dispensing parent education predicated largely on the experience of middle and upper class families, "friendly visitors" made their way to the homes of the poor and indigent. Though these traditions were temporarily replaced by settlement houses (Weiss, 1993) where a range of services in addition to parenting education were provided, they demonstrate how this nation fashioned its earliest commitment to parent education and support—a commitment that supported parents and simultaneously underscored the nation's obligations as a part of its social contract with families in need.

Both the child study movement and commitments to assist the poor expanded through the 1920s and 1930s, giving way episodically to national emergencies associated with the great depression and the world wars. Not until the aftermath of World War II and the emergence of the War on Poverty did parent education crescendo again, this time in the form of energized commitments to parent involvement and empowerment via the provisions of Title I of the Elementary and Secondary Education Act, the provisions for policy making in Head Start, citizen control of education, and the due process provisions of the Education for All Handicapped Children Act of 1975. While each embraced slightly different notions of parent involvement and power, this wave of efforts was predicated upon, and extended, notions of parent education. Moreover, these efforts—in contrast to those of the past—sought and were fueled by greater fiscal and regulatory involvement of government, more clearly affirming America's social commitment to low-income and needy families.

Parent Education: Increasingly Necessary

Just as changing demographic conditions and new knowledge precipitated alterations in the nature of parenting education earlier in this century, more recently, profound changes of the 1970s and 1980s occasioned fresh approaches to parent education. To even the most casual observer, recent changes in the life circumstances in which adults parent their children are evident. Today's families face monumental stresses associated with daily living. A stagnant economy routinely demands family employment in two and three jobs, with such work patterns leaving little time for parenting, much less effective parenting. Growing technology, mismatch of worker skills and employer needs, and off-shore production all create job insecurity, often fueling family discontinuity and fragmentation. Unemployment—once the condition of the unskilled—has affected pink and white collar workers, causing more and more parents regularly to face complexities that make nurturing children difficult. Finally, the rise in single parents, many of them teenage and/or never-married, places heavy burdens on family members and on society.

As these dramatic demographic changes have occurred, so have equally profound advances in our knowledge about the relationship between demographic conditions, family life, and child outcomes. We know, for example, that economically deprived single mothers are more likely to abuse their children physically (Gelles, 1989), that premature low-birthweight babies born into conditions of poverty have a poor prognosis of functioning within normal ranges (Bradley et al., 1994), and that family income and poverty are powerful correlates of the cognitive development and behavior of young children (Duncan, Brooks-Gunn, & Klebanov, 1994). Conversely, we also know that when economic conditions of families are improved, or when services such as parent education and support are offered, outcomes for children, siblings, and families also improve (Gottlieb, 1981; Powell, 1989, 1993; Roberts & Wasik, 1990; Seitz & Apfel, 1994).

Such advances in scientific knowledge—while perhaps not technically or statistically fully understood by parents and the public at large—have filtered into public consciousness. American parents recognize that parenting is important and that they can benefit from help in meeting their parenting

duties. Understanding the challenges of living in a competitive work force themselves, parents want their children prepared for the global economy; yet, parents are increasingly skeptical of the schools. A recent survey by the Public Agenda (1994), for example, noted that one-third of parents feel that teachers are doing a worse job than when they were in school, but 55 percent—a majority—also said they themselves are doing a worse job of parenting. When asked if a child was more likely to succeed if he came from a stable and supportive family but attended a poor school, or if he came from a troubled family but attended a good school, 61 percent of the parents said the child with the more stable family had the better chance. In short, Americans understand the importance of parental competence; it is why they are flocking to bookstores to buy literature on parenting education in unprecedented numbers, why they are buying parenting magazines—numbering 97 according to the National Directory of Magazines—and why they are cruising dozens of electronic bulletin boards that offer advice and conversation ("Focus on Parenting," 1994). Parenting education has become big business in America.

Parent Education: Timely and Doable

Not immune to the need, social service providers across the nation are re-contouring their efforts to provide parent education and family support programs. Not only are the number of parent education programs growing, but the diversity of their sponsorship affirms their appeal and perceived utility (Goetz, 1991). For example, a recent parenting education conference in Boston attracted attenders from hundreds of widely discrepant agencies, all offering parent education. These included programs offered by the visiting nurses, crises centers, mental health centers, pediatric intervention teams, Big Brothers, health clinics, Community Action Agencies, hospitals, community employment and training centers, Head Start, Cooperative Extension, schools, juvenile justice centers, infant-toddler child care programs, the Society for the Prevention of Cruelty to Children, and the Indochinese Psychiatric Clinic, to mention a few.

Some of these programs were established primarily to provide parent education and support. Other such examples include Minnesota's Early Childhood and Family Education Program, Missouri's New Parents as Teachers, and the Minnesota Early Learning Design. By contrast, many programs were not designed with parent education as the primary or original mission; rather, parent education represented a natural evolution of their work or an "add-on." In making changes, programs may have had external support; the Parent Services Project, for example, assists child care centers as they add on parent education and support, essentially becoming family centers. Many programs have not had such support and are forced to navigate inflexible institutional cultures and settings in adding parent education components. Despite the hurdles, however, parent education as a delivery modality is growing, becoming increasingly diverse on virtually every dimension imaginable: sponsorship, funding mechanisms, audiences, intensity, staffing patterns, and evaluation strategy.

Given the increasing necessity of parent education and support programs and their apparent diversity in meeting varying needs, what binds these programs together? Contrary to days past when parent education had a didactic, if not somewhat elitist, orientation that was shunned by many, today's approach is different and more universally adapted. While programs differ in how they carry out their activities, they tend to embrace a common set of principles that serve as glue uniting this generation of parenting education and support programs. Emanating from many domains including child mental health, health, special education, and child welfare, a working set of principles has emerged to include: (a) a focus on prevention and optimization rather than treatment; (b) a recognition of the need to work with the entire family and community; (c) a commitment to regarding the family as an active participant in the planning and execution of the program rather than as a "passive client" waiting to receive services; (d) a commitment to nourishing cultural diversity; (e) the promotion of independence and interdependence in contrast to dependence; (f) a focus on strength-based needs analyses, programming, and evaluation; and (g) flexible staffing (Dunst & Trivette, 1994; Family Resource Coalition, 1990; Kagan et al., in press). In practice, adherence to these principles suggests that today's parent education and support programs—unlike many of the past—endow families with primary responsibility for their children's development and well-being, en-

vision healthy, functioning families as the basis of a healthy society, and understand families as a part of a system enmeshed with neighborhood and community. Today's programs meld the commitments of the child study, settlement house, self-help, and community development efforts. As such, they are potent vehicles for supporting familial and social contracts simultaneously.

PARENTAL COMPETENCE VIA EDUCATION AND SUPPORT: ISSUES AND STRATEGIES

Current Issues

Unlike many domains where disagreement between parents and providers reigns, in parent education and family support there is surprising unanimity of thought regarding the need for enhanced services. Less clear, however, are the issues to be considered as such services are crafted. Several, discussed below, convey the flavor and complexity of the debate.

The Definitional Issue. Throughout this paper and throughout discussions, nomenclature around parent education changes. Sometimes called parenting education, parent empowerment, family education, family life education, parent support, family support, or any combination of the above, the terminology is fluid, perhaps reflecting the diversity and fluidity of the programs. As this brief history has indicated, the programs have multiple antecedents, and emanate from different disciplines, which further complicates consensus around terminology. Such ambiguity is burdensome in that it demands that each discussion commence with a delineation of terms.

The Equity Issue. As the above discussion suggests, parent education is alive and well in the marketplace, with affluent consumers exercising choice and purchasing information, often from multiple sources. Simultaneously, low-income parents have far more limited access to formal parenting programs, have less discretionary income with which to purchase information, and have children who might benefit considerably from their engagement in parent education efforts. If parent education is left to market forces alone, the wealthy will become more information rich, while the poor will become not only comparatively, but actually, more information poor. This chasm separating the affluent and non-affluent is widening irrespective of need.

The Voluntary/Involuntary Issue. Presently, most parent education and family support programs are voluntary, with parents determining the nature and length of their engagement. Some programs have fixed durations, but parents—because of their voluntary engagement—may opt out at any time. Increasingly, as programs receive public funding and are designed to ameliorate a particular problem—e.g.,substance abuse, child abuse and neglect—their voluntary nature is in question. Changing from a voluntary to a required program may alter the intent and nature of family support, violating some of its basic principles.

The Cultural Competence Issue. Underneath the glowing face of parent education and support lie widely different ideas about what constitutes effective parenting, varying often—though not always—with cultural predispositions and orientations (Caldwell, Greene, & Billingsley, 1994; Lynch & Hanson, 1992; McAdoo & Crawford, 1991). Discerning multiple understandings of what constitutes competence across and among cultures, as well as delineating effective ways to build parental competence while nourishing diversity remain a challenge.

The Quality Issue. Because parent education and family support have grown fairly rapidly, and because they have emerged from different professional traditions, important efforts—notably those of the Family Resource Coalition—to address program quality are embryonic, but not yet widespread (Dunst, in press). Uncertainty regarding specific variables associated with quality outcomes prevails. Overall, there is little specification regarding the competencies, training, or credentials needed for working in the programs. Tools to evaluate program quality and methods of program accreditation are only just emerging.

The Results Issue. While it is appropriate to demand results from parenting education and family support efforts, the programs must be recognized

for what they are and are not. Parenting education efforts have not been established as social panaceas to rectify the major ills of malnourished, malfunctioning communities. They do not replace efforts in community development or major employment initiatives. They do, however, enhance overall parental competence and self-efficacy, parents' knowledge of child development, and parents' capacities to parent more effectively. It is for these outcomes that parenting education should be held accountable and around which evaluation should occur. To date, only sporadic evaluation of parent education and family support has taken place. Much of the data collected have been on pilot programs and have been conducted by the program developers without random assignment of participants (Powell, 1994; Weiss & Jacobs, 1988). More emphasis needs to be placed on durable, scientific, objective evaluations that measure the results and outcomes the interventions are designed to accomplish.

The Linkage/Coordination Issue. With rapid growth in parent education and support, the need to engage in cooperative planning, coordination of service delivery, and infrastructure development across programs, communities, and states is becoming acute (Bruner, 1994). In some locales, voluntary networks of parent education and family support programs are developing, fostering linkages that promote coordination and access (Farrow, 1994).

Potential Strategies

Assuming that parent education and family support are deemed important endeavors, there are several strategies open to policy makers. First, and most dramatic, parent education and family support may be deemed so important to the nation's collective well-being that the programs would be rechristened a merit good and supported in a manner commensurate with other merit goods—libraries, fire stations, parks, or education.

Second, and alternatively, parent education and family support might be deemed a worthwhile endeavor for all parents, but not at public expense. Given the existence of a free market and the inroads parent education has made therein already, it might be considered appropriate to commodify parent education and family support. This strategy would have the advantage of very limited governmental outlays and the disadvantage of exacerbating inequity of access and lack of quality control. Moreover, it might deny services to those who need them most.

Third, a mid-way strategy could advance a targeted approach wherein some parent education and support programs could be nurtured by leveraging the market; incentives could be provided and public/private sector collaborations fostered. For families not financially able to purchase parent education and support via the market, such services could be made available publicly by building on existing programs and legislation, including Family Preservation and Support, Even Start, Head Start, Family Literacy, the Comprehensive Child Development Program and/or New Parents as Teachers. Such efforts would need to provide for quality enhancements, longitudinal evaluation, and service coordination. This strategy has the advantage of more equitable access to services across the population, coupled with some government investment; it has the potential disadvantage of stigmatizing services and segregating families by income.

Fourth, transcending the above strategies, we must recognize that the conditions of families are affected by every piece of social legislation. While in process, all new legislative launches, reauthorizations, and consolidations should be evaluated with an eye toward their familial consequences; provisions for a "family" litmus test of sorts might be considered. Further, and most critical, the advancement of parent education and support cannot be left only to isolated bills; it must be regarded as an integral component of major pieces of social legislation—welfare reform, parental leave, job training, and employment. In this way, parent education would be infused into a broad range of social supports, enhancing this nation's commitment to fostering strong and healthy families.

As the nation considers many new contracts, let it not forget the most significant of all—the durable familial contract humans undertake with their children. It cannot be too much to ask our great nation to support parents as they honor their contractual obligations to their children and our future simultaneously.

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Avance Family Support and Education Program

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It is indeed an honor and pleasure for me to be here with you today to discuss the future of children and parents in our country. I am the parent of three very energetic children, ages 11, 14, and 19, and I can attest that parenting can be most challenging. Even when one has sufficient resources and support, parenting can, at times, be overwhelming. Yet no role is as important and can have greater influence than the caring for and the development of young children.

It is in the family where basic values need to be learned, where the foundation for language, learning and a conscience is formed, where the young child can develop a positive self identity, and appreciation and respect for others. Parents, as the first teachers of their children, should impart knowledge, manners and absolute societal values such as honesty, respect, the work ethic, responsibility and compassion. Effective, competent parents demonstrate love, understanding and caring; give attention, respect and support; build trust and develop positive relationships. Parents also transmit culture and provide a sense of belonging, purpose, hope and security. Able parents should provide stimulating, enriching experiences that will prepare children for school and life. Parents need to be disciplinarians—guiding, supervising and "training their children on the way they should go." Most importantly, parents are primarily responsible for providing the basic needs of food, clothing, shelter, education and health care.

What do parents need for the development of the next generation of responsible citizens, productive workers and able leaders? To begin with, parents need to have had good parenting models—hopefully their parents fulfilled this role. Next, parents' access to a good education and job training impacts their ability to obtain and maintain a job in order to provide for their family's needs. Ideally, a parent needs a spouse to model mutual love, respect and support to children. Parents need to be in sound physical and mental health. Parents need to schedule time for their children and participate in family activities. Working parents need affordable, accessible, developmentally-appropriate child care. Parents need support from other parents, relatives, neighbors, friends, and a Supreme Being to help them cope with the challenging demands of parenthood.

Each one of us plays a vital role in supporting the basic unit of our society, the family. Strengthening parental competence, families and communities is a shared responsibility that can be accomplished only if we all work together. The federal government cannot do it alone—it must be done through public-private partnerships consisting of the federal, state and local governments; business, religious and civic leaders; education, health, social and nonprofit organizations; volunteers; philanthropists; parents and children. We need to bring back the village concept where all are connected by one spirit, each possessing and contributing his or her unique gifts for the common good. Children's lives should not be left to chance—but "the village" should help children develop their God-given potential that will enable them to find their own place in the sun. These actions, while they may appear altruistic, are for the

safety and quality of life of our communities, for our future economic well-being and for the preservation of our country.

It has been conservatively estimated that future losses to the economy stemming from the effect of just one year of child poverty for 14.6 million children will reach as high as $177 billion (Children's Defense Fund, 1994). This does not include the hundreds of millions of dollars spent on children who repeat grades or require special education; the tens of billions of dollars in health costs projected to come from the failure to prevent long-term disabilities; and the costs of teen pregnancy and parenthood, violence, incarceration, and welfare that poverty leaves in its wake.

I became involved in the field of parenting education and family support 25 years ago. I realized that being an effective parent was a skill that needed to be learned, developed and supported and that no formal institution existed to fulfill this mission.

As an elementary teacher, I was very concerned with the educational outcomes of poor Hispanic children who had a 50 percent drop-out rate. I saw the negative consequences of not supporting and helping parents before the child entered school. I began teaching at midyear and was assigned a class of 35 first-grade children from four classrooms who, their teachers had already determined, were going to fail. The school system had given up on these six-year-old children because they had entered school so ill-prepared. Their language and cognitive skills were limited both in English and Spanish. They couldn't hold a pencil or draw a circle. In college, I was taught that by the age of 4, children learn half of what they will learn from birth to age 17, yet these children had had few experiences during their critical formative years to stimulate that learning.

I administered an informal attitudinal survey to the parents of the children whom I taught. I discovered that these parents loved their children. However, they thought that education began at school. These parents were not aware of the critical formative years and the essential skills that children are expected to know, prior to entering school. They did not know the importance of talking and reading to their children, encouraging children to question, and allowing them to explore and experiment. They thought the school teacher was their child's first teacher. I also found out in the survey that these parents, who had only reached the 7th grade, were not very hopeful that their children would go any further in school than they themselves had gone.

My mother, who had a third-grade education, never lost the hope and dreams for her children to do well in school and in life. Being poor or having to overcome obstacles makes life more challenging, but poverty alone does not cause the hopelessness. My father died when I was two, leaving my mother a widow with five girls, one year apart. That same year, her own mother died of cancer. We temporarily lived in a housing project. We were poor economically, but we were rich in love, support and family interactions. My mother had high expectations and aspirations for her children and the energy to nurture, guide, supervise, protect, provide and inculcate important morals and values. All of my siblings knew we were unique and that we had a special purpose in life. My mother would say that we could become anything we desired. For that reason, and with continued support and opportunities, I hold my Ph.D. today. I asked myself, "What makes the difference between some poor children who succeed and others who do not?" What depletes people of energy, motivation and hope? I concluded then that it was *lack of support.*

My mother received support. It was this support that kept her strong, provided her knowledge and enabled her to overcome obstacles and become and remain an effective, competent parent. The support came from many sources, including my grandfather who moved in to care for us while my mother worked. He made us go to church, pray and read the Bible. He, like my mother, disciplined us, provided love, taught us values and had high expectations. My mother worked as a seamstress, made and sold beautiful earrings and received Social Security. In addition, she received support from the extended family and from visiting nurses who went into homes in the 1940s to teach parenting skills. There was the concept of neighbor helping neighbor. They borrowed sugar, cared for each other's children and protected each other's homes. It was this kind of environment that I wanted to recreate in poor Hispanic communities.

There are numerous family support programs that have developed across the country—Avance is only one program, working with predominantly poor Hispanic families. These programs cost far less than building jails and prisons and putting more police in the streets. It costs $40,000–60,000 a year in Texas

to imprison a person, yet we know that the current penal system does not work as demonstrated by the high recidivism rate. In comparison, it costs between $1,500 and $2,000 annually per family at Avance—and we know that prevention programs like Avance produce results and make a difference in reducing or eliminating the factors that lead to crime and incarceration. Avance embraces the philosophy that people can change and need opportunities to help themselves and their families, and that they merit dignity and respect.

METHODOLOGY

The core component of Avance is a nine-month parent-education program for both mothers and fathers, consisting of monthly two-and-a-half-hour sessions—one hour devoted to toy making, one hour to child-development instruction, and half an hour for a community-resource speaker. The parents are taught that they themselves can be educators, and they are shown concretely how to facilitate their own children's development. While the classes are going on, the young children of the participants get good care in the same building. Participating mothers take part in child care once a month where they can observe a child-care specialist at work while interacting with the children. They also get monthly home visits during which the home visitor video tapes mother-infant interactions. These tapes are used in subsequent classes.

The Avance experience has pointed to the importance of ancillary services: transportation to the center; home visits for the new parents as a transition to participating in the activities of the center; day care; pleasurable outings, e.g., to the circus; graduation ceremonies as a focus for solidarity and reward for accomplishment; family planning; learning how to use community resources; driver education. In other words, Avance tries to offer one-stop support; many needs can be met in one place. The approach has grown increasingly comprehensive over the years. In a variety of ways, parents are taught basic social skills as an integral part of the program. Staff training and supervision are an ongoing vital part of the activity.

The trained Avance staff, 80 percent of whom are Avance graduates, become role models and advocates for the families. Positive and nurturing relationships with staff makes the difference in the participants. The dedicated staff builds the trust that leads to an improved self esteem of the parent—which eventually improves the relationship between parent and child, husband and wife, neighbor and neighbor. Avance begins with the strengths that the parents bring and the love that they have for their children. The birth-to-three-years core program is the catalyst that sets the wheel in motion. Once parents realize that they have created positive change in their children, hope is rekindled for themselves and the whole family.

The Avance comprehensive model has simultaneous growth paths for parents and children. After the birth-to-three-years core parenting program, parents have opportunities to learn English, obtain a G.E.D., enter college and enroll in job training and assistance in job placement. Parents become more empowered with each phase of the program. The children also have their own path from infant stimulation in the home and at the child care center, to preschool education in Head Start, HIPPY, and other positive growth experiences in Boys and Girls Scouts, tutoring, mentoring, recreation programs.

Avance provides services at 50 family centers located in schools, churches, public housing developments, Boys and Girls Clubs, and community centers in San Antonio, Houston and South Texas. Avance Area Chapters are governed by a local Board of Directors representing a cross-section of the community and are funded through public-private partnerships consisting of the federal, state and local governments; corporations; foundations; United Way; fundraisers; and volunteerism. With a $4 million budget and a staff of 200, Avance serves over 6,000 individuals annually. In addition, training, technical assistance, materials development, research and evaluation, and public policy activities are conducted in our National Office.

EVALUATION

Avance has empirical data that substantiates its effectiveness. A research grant from the Carnegie Corporation of New York confirmed that Avance mothers, after intervention, provided more nurturing, responsive, structured and stimulating home

environments for their children in which to grow and learn. They talked more with their children and saw themselves as their first teachers. They had an increased sense of parental efficacy, parental knowledge and skills, and increased knowledge and use of community resources. Research indicates that these results are correlated with later school success.

In another research study, funded by the National Center on Child Abuse and Neglect, similar outcomes to the Carnegie study were found. Parents gained knowledge in child growth and development; changed their attitude toward corporal punishment, breaking the vicious cycle of child abuse; and became more hopeful about the future for themselves and for their children.

A seventeen year informal follow-up study of the first Avance class demonstrated a reversal in educational outcomes from one generation to the next. Although 91 percent of the parents had dropped out of school, 94 percent of their children who were under the age of three when they attended Avance, had graduated from high school—and 43 percent of them were attending college. Avance impacted the parents as well—57 percent of them returned to school and received their G.E.D., and 64 percent of the mothers who completed their G.E.D. had attended college or a technical training program.

Avance has proven that prevention and intervention do work, not only for low-income Hispanic families, but for low-income Anglo and African-American families as well. These efforts have been made possible by public-private partnerships and include funding from federal initiatives such as Even Start, Head Start Zero to Three, the Family Preservation Act, and the Empowerment Zone. It is this type of shared responsibility—public-private partnerships—that I earlier proposed be used to strengthen parental competence. All families need the right kind of support, education and opportunities to improve their conditions and gain new attitudes, knowledge and behavior. Parents and children who have received support were the fortunate ones—they now have an opportunity to share in the American dream and to exercise their inalienable rights of life, liberty and the pursuit of happiness. Many in the target population of Avance are parents who have been victims of child abuse and neglect, lack knowledge in child growth and development, and experience depression. If these conditions had continued to exist and support services had not been available, then one can paint a scenario as to what would have happened to the children in these families. These parents would not have had the opportunity to gain the knowledge and have the energy to nurture, guide, and supervise their children. These children could have possibly been neglected or physically abused. They would have likely been socialized by television violence, sex, and materialism. The toy guns of these children could have eventually become real. Their need for a sense of belonging, worth and purpose in life could have been met by gangs, with their own set of inappropriate values, mores, and destructive behavior. These children may not have felt that they were part of society and could have possibly developed resentment and anger toward their family and society at-large.

For too long we have blamed and ridiculed parents, fined them or taken their children away for failed policies and programs. We can no longer solely blame parents but instead support them with effective services and programs. In working with the poorest and at times most dysfunctional families, we have seen parents learn new skills, change attitudes, gain confidence, become more hopeful—thereby preserving the family unit. Throughout my 21 years at Avance, working with thousands of individuals a year, I can count on one hand the few cases in which we recommended having children removed from their parents.

Avance has testimonials from numerous parents who have been able to keep their children because of the support they received from the program. Beatrice Torres, whose child was going to be removed because, in a moment of anger, she unintentionally broke her child's leg, was featured on Oprah Winphrey's documentary on child abuse entitled "Scared Silent." Beatrice had been sexually abused as a child and had never received support from anyone. Because of Avance's intervention, the healing process began. Avance taught her parenting skills and helped her improve her self esteem. She was able to function better as an individual and as a parent and was able to keep her children, get married and complete her G.E.D.

Mary Ann Perez, selected randomly by a producer for an Avance video, was asked "What would life be like without Avance?" She responded, "I do not know, perhaps I would be in the state hospital, on

drugs or on Guadalupe Street as a prostitute." Mary Ann had been on drugs and was a prostitute when she came to Avance—and her two children were going to be removed from her due to severe neglect that endangered the children's lives. She states in the video, "I used to do these things. That person—I no longer am today. Because of Avance, I take care of my children now. They have perfect attendance and my older child is on the honor roll." Mary Ann was also a victim of sexual abuse and she gave up on life when her fiancee met a violent death. Before Avance intervened, she had not had a strong support system to help her overcome these obstacles. Avance helped her to get off drugs, taught her how to take care of her children and to help herself. Her children are happy, healthy and thriving because of the support she received. Mary Ann is completing her G.E.D. and is a Girl Scout leader in the public housing project, where she lives.

Sherri Rodriguez, featured in the MacNeil Lehrer Newshour, was on drugs, an alcoholic and had a 12-year-old daughter who was pregnant and out of control when Avance knocked on her door. Sherri and her family needed help. She stated that now she is doing for her grandchild what she should have done for her children. Sherri took legal custody of her grandchild, who is now four and extremely bright. Sherri and her older son received their G.E.D. She is an honor student in a local community college studying to become a social worker.

Sylvia Valdez, a single parent with four children, was on welfare and living in a housing project. She was extremely depressed when Avance knocked on her door. Today, she is earning $19,000 as a secretary, her older daughter is in college and her other two children are in the gifted and talented program in school. She reunited with her husband, who had been in jail while she was attending Avance, and they are in the process of buying their own home. The successes of these families are not the exception—they are the norm for Avance graduates.

One of the reasons our country is in crisis is because poor and middle class families have not been adequately supported. The embers will ignite if effective laws, policies and programs are not implemented to ameliorate the social, health and economic conditions plaguing American families. The middle class cannot continue to erode and the gap between the "haves" and the "have nots" cannot continue to widen. We must straighten the nation's course with visionary problem-solving. We are warned in Malachi that we need to turn the heart of the fathers to the children, and the heart of the children to their fathers, lest the earth will be destroyed. The signs are already here as we read about children killing parents, parents hurting and drowning children and children killing each other. There is a lack of respect for law and order and a lack of respect for the highest office in this land. We do not need a foreign enemy to threaten the security of this nation. If our leaders fail to support parents in their very important role, then our country's moral fiber, our quality of life, our economic competitive edge in the global world market, our freedom, our democracy, our national security and our very existence are all in jeopardy.

In the State Dining Room of the White House there is a famous quotation by John Adams describing some of the important virtues that able leaders should possess. Part of it reads, "May none but honest and wise men ever rule." The Bible also says about leaders, "Thou shalt provide out of all the people able men, such as fear God, men of truth, hating covetousness." What can our chosen able leaders do to alleviate the multitude of problems facing our society? The answer lies with families and children. Our families and children are the barometers that measure the strength of our communities and our nation. They are an expression of how responsive our leaders have been at addressing issues such as poverty, health care, jobs, job training, child care, education, housing, violence in our communities and in our media, and parent education and family support programs. We can all work together to change obstacles into opportunities, despair into hope, failure into prosperity, fatalism into fulfillment, divisiveness into unity and hate into love. The following are but a few recommendations for action:

- Ensure that public policy sustains and strengthens families (jobs, child care, etc.)
- Support the infrastructure, research, training, development and expansion of existing family support and education models (take them to scale)
- Support coalitions of existing family support programs (to provide a holistic, comprehensive, continuous approach)

- Begin early (the earlier the intervention, the longer lasting the effects)
- Begin in the home (where the family is most comfortable and transportation and child care are not barriers)
- Promote community-based family centers (staffed by people from the community and governed by local Boards of Directors)
- Offer community based parent education and support (in schools, hospitals, and community centers)
- Provide comprehensive services (families living in poverty often have multiple and diverse problems and needs)
- Provide integrated services (fragmentation tends to confuse and demoralize families)
- Provide structured, skill-based and goal-oriented programs (family and program impact are measurable)
- Promote public-private partnerships (where the Federal Government is a leader and/or partner)
- Adopt policies at the federal, state and local levels that will enable and facilitate interagency collaboration (Education, Housing, Health, HHS)
- Establish standardized eligibility criteria across programs (to allow families continuous access to needed services and children a continuum of intervention)

I want to end with a story about a very wise, able, elderly man—kind of simple—who didn't have a college degree, but all the people in the community would go to him for advice. Two very selfish envious seniors ready to graduate from a very prestigious university wanted to discredit him. They said, "We will hide this little bird in our hands and ask him if the bird is dead or alive. If he says that the bird is alive, we will snap its neck and kill it. If he says that the bird is dead, we will open our hands and let it fly away." They called the townspeople and said, "We are going to show you that he is not that wise." When they asked the old sage the question, he responded, "The fate of the bird is in your hands." Ladies and gentlemen, the fate of our children, families, communities, country and our very existence—lies in your hands. I trust and pray that you will exercise prudent judgment in making the right decisions that will affect us all. Thank you.

Parenting Adolescents: What Legislators Can Do to Support American Families

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Being a parent of an adolescent in America today is a formidable challenge. Dramatic changes in the structure of American families have occurred within our lifetimes (Hernandez, 1993). These changes have had serious repercussions on the decreasing time parents have to spend with their children and subsequently for adult guidance, supervision, and the transmission of values (Zill and Nord, 1994). Equally dramatic are the risks and opportunities faced by all adolescents at increasingly younger ages—choices about drug use and sexuality, the use of lethal weapons such as firearms, and challenges to their investment in learning. For all too many young people in resource-poor communities, their very survival into adulthood is in jeopardy (Hechinger, 1992). Over 80 percent of American parents and adolescents agree that it is much more difficult growing up in the 1990s than in previous generations (Princeton Survey Research Associates, 1993).

Large-scale economic and sociocultural transformations have had profound effects on family life. Understandably, we are uncertain about how to be good parents during our children's adolescence and have little guidance about how to proceed. While an industry of books, videos, and experts exists for parents with young children, nothing comparable can be claimed for parents with adolescent children. A social consensus holds that parents should be knowledgeable about infant and child development, because they are crucial to their young child's future (Task Force on Meeting the Needs of Young Children, 1994). No such consensus exists for the adolescent years. Furthermore, public policies are at best indifferent, and at their worst, inimical to supporting families in their critical role during the second decade of their children's lives (U.S. Congress, Office of Technology Assessment, 1991). There is a great deal that can be done to redress this situation.

CHANGING VIEWS OF THE IMPORTANCE OF PARENTS IN ADOLESCENTS' LIVES

A poignant response of young people to questions about why they join gangs is that the groups become "the family they never had." Their responses are compelling testimonies to a fundamental human need for close, reliable relationships within a supportive, protective group that confers respect and identity while recognizing competence (Hamburg, 1992). In survey after survey, adolescents from all ethnic and economic backgrounds lament the lack of parental attention and guidance when they need it most: for making educational and career decisions, forming adult values, and assuming adult roles (Princeton Survey Research Associates, 1993).

Adolescents' views are supported by 15 years of research, ranging from families and adolescents on Midwestern farms undergoing economic decline to African-Americans in poor neighborhoods who raise

successful youth, that concludes: a supportive family characterized by warmth and authoritativeness (parental responsiveness to the changing cognitive and social capacities of the adolescent; firm discipline; communication of high expectations for achievement and ethical behavior; democratic, mutually respectful parent-child relationships), close supervision, and constructive ways to deal with conflict, can provide powerful protection against the risks of engaging in unhealthy practices and antisocial behaviors (Small, 1990; Steinberg, 1990). Research also attests to families as key to enhancing educational achievement during the adolescent years (Task Force on Education of Young Adolescents, 1989; Eccles and Harold, 1993). Conversely, a substantial body of research indicates that poor parenting, marital discord, and inadequate supervision and discipline lead to adolescents' involvement in antisocial peer groups and poor outcomes (Dryfoos, 1990).

Yet persistent and pervasive misconceptions that adolescents constitute a monolithic oppositional culture against adults continue to influence contemporary relationships between parents and their adolescents, parental expectations, and the formation of public policies. Conventional wisdom holds that hostility and conflicts between parents and adolescents are inevitable, and that parents should disengage or "detach" themselves from adolescents in the interests of fostering adolescents' needs for autonomy and individuation (Steinberg, 1990).

These prevailing stereotypes are based on a previous generation of research on parent-adolescent relationships in troubled families. Such stereotypes contribute to ever increasing age-segregation in the United States with few regular contacts between adolescents and adults that can counter negative peer and media influences (Hernandez, 1993).

Creating a social consensus that families of adolescents are essential to their future prospects must be a high priority for leadership from all sectors of society. The preparation of professionals who work with adolescents—teachers, nurses, social workers, physicians, psychologists, youth development workers, and others—must be addressed (Millstein, Petersen, and Nightingale, 1993). Opportunities to strengthen and support families of adolescents lag far behind current scientific knowledge and must no longer be neglected.

KEY OPPORTUNITIES FOR PROGRAMS AND POLICY

A cursory look at innovative programs for adolescents, legislation and public policies, indicates that families are almost always overlooked as a vital part of adolescents' lives (U.S. Congress, Office of Technology Assessment, 1991). While greater public understanding about their constructive role in adolescents' lives is needed, the development of innovative approaches can build toward such understanding in the near-term. Some cross-cutting themes for considering key opportunities to support families of adolescents include:

- A wide range of *community organizations* and *institutions*—cultural, arts, religious and youth organizations, health care systems, schools—should examine their current practices regarding the involvement of parents in appropriate activities with adolescents. When parents are explicitly excluded, the reasons for such exclusion should be discussed.

- *Work-related policies and practices* that enable families to spend more time with their adolescents are likely to increase opportunities for better parenting, family relationships, and outcomes for adolescents. Two-thirds of employed parents with children under 18 report a troubling time deficit in this area (Zill and Nord, 1994).

- Legislation and policies should re-examine current arbitrary age cutoffs for *parental leave* and *child care tax credits*. Proposed legislation and policies should be informed by current knowledge about the importance of families during adolescence, particularly during the early adolescent period when their children are 10–15 years of age.

- The neighborhoods in which families raise adolescents affect parents' and other caregivers' practices regarding concerns about safety and access to and participation in community networks such as schools and religious groups. The nature of *community*

infrastructure or social capital in different communities can support or compromise families' capacities to be effective parents during adolescence.

SELECTED EXAMPLES: OPPORTUNITIES FOR SUPPORTING FAMILIES DURING ADOLESCENCE

Sustaining Parent Involvement into the Middle and High School Years

As children become adolescents, the percentage of parents who are actively involved in school activities declines. Approximately three-quarters of American parents report high or moderate involvement in schools when their children are eight to ten years of age. By age sixteen, only fifty percent of parents report such involvement (Zill and Nord, 1994).

Ample evidence exists that parents who desire good school achievement must sustain their involvement in their children's education from the elementary through the middle and high schools (Zill and Nord, 1994; Task Force on Education of Young Adolescents, 1989). In doing so, parents will encounter barriers to their participation, because existing school practices, including policies and teacher attitudes, have long accepted the absence, and often discouraged the involvement, of parents beyond the elementary school years (Eccles and Harold, 1993).

While they are relatively rare, schools are recognizing that parental involvement beyond the elementary school years is essential to students' performance. Parents of adolescents can be engaged in several productive ways: Schools can organize parent education and support groups to learn about normal adolescent development, exchange ways to guide adolescents, and shape a community of shared values regarding appropriate behavior; communicate with parents about programs and students' progress on a regular basis; provide specific pointers on how parents can assist with homework and other learning activities, including community youth service; involve parents as volunteers in schools; include parents in school governance committees; and create partnerships among schools, parents, and key community organizations in joint responsibility for adolescents' educational achievement and healthy development (Epstein and MacIver, 1990).

If we hope to make any significant progress in improving the educational performance of American students, significant changes in educational policy, specifically the attitudes and practices of middle and high school teachers and principals toward the involvement of adolescents' parents, must be made. Professional preparation of educators must include coursework and practica to foster the participation of parents of adolescents in the schools and support for their children's education.

PREVENTIVE APPROACHES DURING THE CRITICAL TRANSITION FROM CHILDHOOD TO ADOLESCENCE

Major life transitions represent opportunities for preventive approaches (Hamburg, 1993). Early adolescence, from approximately 10 to 15 years of age, represents a transition when two approaches—parent peer support groups and providing health guidance to parents and adolescents—can be helpful in transforming a relationship based on changing needs and capacities of both parents and adolescents. These approaches can take place in a number of settings: the former in schools and religious, community and youth organizations, and the latter wherever preventive health care services are delivered to adolescents.

Parent Peer Support Groups

One preventive approach during the transition from childhood into adolescence is parent support and education groups in which information about handling the stressful transition from childhood to adolescence, normal adolescent development, communication skills and ways of renegotiating the parent-adolescent relationship, and linkages with community resources are shared among parents (Small, 1990). Such groups are common for parents of infants and young children, but not widely available for parents of adolescents.

Anticipatory Guidance as Part of Preventive Health Services

The Guidelines for Adolescent Preventive Services (GAPS) of the American Medical Association (AMA) recommend that parents or other caregivers of adolescents receive health guidance at least once

during early, middle, and late adolescence as part of well-adolescent examinations (Elster and Kuznets, 1994). This recommendation recognizes the critical role of parents and other significant adults in promoting the development, health, and well-being of adolescents. Anticipatory guidance to parents of infants and young children is accepted health practice, but not yet widely recognized for parents of adolescents.

The AMA recommends that parents receive information on normative adolescent physical, sexual, and emotional development and signs and symptoms of disease and emotional distress. Parents should learn ways to promote healthy adolescent adjustment, including those to help adolescents drive responsibly, monitor their adolescent's social and recreational activities, and restrict sexual behavior and the use of tobacco, alcohol, and other drugs. The expected benefits of this guidance include improved family communication and relationships and the promotion of healthy lifestyles.

WORKPLACE POLICIES: RECONSIDERING PARENTAL LEAVE

Parental leave policies are usually limited to parents of young children and to those with elderly parents (Task Force on Meeting the Needs of Young Children, 1994; Family and Medical Leave Act of 1993). Public and workplace policies regarding parental leave and flexible working hours (including compressed work weeks, job sharing, telecommuting, and daily flextime) are based on the assumption that once a child is nine or ten, parental or adult supervision is no longer essential. To the contrary, unsupervised hours, typically after school, can be a high-risk time for high-risk behavior if adolescents are not adequately supervised and engaged in constructive activities.

About 40 percent of a young adolescent's waking hours are discretionary, i.e., not committed to activities such as school, homework, chores, work, and personal maintenance (Task Force on Youth Development and Community Programs, 1992). Many young adolescents spend virtually all of this time without companionship or supervision from responsible adults, often exposed to negative peer pressures. Unsupervised after-school hours represent a time when adolescents may engage in dangerous and even illegal activities. These young adolescents stand a greater chance of engaging in substance abuse at the rate of twice the risk of peers who are supervised (Task Force on Youth Development and Community Programs, 1992).

The range of workplace policies now extended to parents of younger children, including part-time work with benefits, should be available to parents of adolescents to enable them to become more involved in middle and high schools, as volunteers in youth organizations, and to spend more time than they do now with their adolescents. In addition to responsive workplace policies, the availability of high quality, community-based programs for adolescents during the after-school, weekend, and vacation hours is highly desirable (Dryfoos, 1994).

SCHOOL-AGE CHILD CARE POLICIES: PROGRAMS AND TAX CREDITS

After-school programs for elementary-aged children are growing, but those for young adolescents remain relatively few (Task Force on Youth Development and Community Programs, 1992; Carnegie Council on Adolescent Development, 1994). Again, the assumption that adolescents do not require supervision or constructive activities drives the unavailability of these programs.

The child care tax credit should be considered for extension to at least the early adolescent period (ages 10–15) so that families can benefit from placing their young adolescents in high quality after-school programs to the same extent that they now benefit from placing young children in child care and early childhood centers, and elementary-aged children in after-school programs.

The Carnegie Council on Adolescent Development's report, *A Matter of Time: Risk and Opportunity in the Out-of-School Hours,* provides examples of positive outcomes associated with young adolescents being involved in a wide range of after-school activities (Dryfoos, 1994). The cost-saving arguments for capping the upper age limit for child care tax credits should be reevaluated in terms of the costs of incarceration and treatment of status and juvenile offenders. The estimated costs for juvenile incarceration range from $25,000 to $75,000 per

year depending on the state and nature of the facility (Earls, 1994; Sipchen, 1994; Treaster, 1994; Committee for Economic Development, 1991). Treatment of juvenile offenders is estimated at one-third the cost of incarceration. The per-adolescent cost of after-school programs is considerably less than both, in the range of one-fifth the cost of incarceration.

Different points of view abound regarding why we find ourselves in our current predicament regarding the appropriate roles and responsibilities of American families in the lives of adolescents. Despite the disagreements, the combination of research findings with the views of adolescents is powerful enough to guide solutions to the predicament. Parents and close caregivers are critical for the adolescent to emerge from adolescence healthy, educated, and prepared for adult life. Parents appear to be less certain of their roles and responsibilities, reflecting perhaps the lack of consensus and available guidance society-wide. All together, our discussions about how parents, professionals, and leaders of different sectors (governmental, business, media) can better address support for families during the second decade of life are likely to be spirited.

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The views expressed are not necessarily those of the Carnegie Council on Adolescent Development or Carnegie Corporation of New York. For further information and references, contact Jenifer Hartnett at 202-429-7979. My thanks to Hartnett and Timothy J. McGourthy for their research assistance in the preparation of this paper. A. M. Mortimer prepared the list of references.

How Parents Can Obstruct and Enhance Adolescent Development: Some Observations and Policy Implications

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INTRODUCTION

Parenting is a full time, demanding, often relentless job, for which all adults receive *no* formal training. More circumscribed work and tasks—computer programming, data entry, driver's training, becoming a physician—have complex standards and prescribed training procedures. In part because of the inadequate prior training, becoming and continuing to be a parent remains one of the most taxing and baffling of all human responsibilities. To be sure, it is also one of the most gratifying of experiences, when hoped for short term and long term outcomes are fulfilled, and parenting is not a persistently confusing and overwhelming experience. But, unfortunately all to often, short term and long term consequences of parenting seem to lead to dashed hopes and lingering disappointments and unhappiness.

The immense difficulty of being a parent is especially apparent during the adolescent era, years of development reaching from the onset of puberty to the late teens. In this brief essay, I consider specific features of the adolescent (or teenage) era, their implications for parenting and how parents cope with the many and varied stresses involved with caring for their adolescent sons and daughters.

Adolescence

The adolescent years represent a "vulnerable moment." A series of interconnected, frequently stunning, changes are unfolding—for the adolescent *and* his or her family—at a sometimes rapid rate. While scholars and researchers no longer believe that this period is *only* characterized by turmoil, we do know that many important new biological and psychological events and processes are occurring (Feldman and Elliot, 1990; Powers, Hauser, and Kilner, 1989).

Several aspects of adolescence clearly influence the relationship between an adolescent and his or her family: 1) Critical hormonal changes are in process, beginning with the pubertal years, and leading to dramatic changes in growth, and secondary sexual characteristics. These new physical changes can trigger inner conflicts for the rapidly growing teenager, all too often unprepared for new bodily shapes, unbidden desires, and their repercussions; 2) Important cognitive changes (Keating, 1990) are also occurring, involving increasing interest in abstract reasoning, self reflection, and self image. At times the self consciousness of a teenager appears vast, leading to intense embarrassment, often set off by a parent's awkward question, comments, or new features of appearance; 3) Many of the processes originally described by Erikson involving the integration of self images and the forming of identity are evolving, calling adolescents' attention to their significance in the community, and their continuity with their past and envisioned future (Erikson, 1958); 4) Most adolescents are beginning new schools, middle and high school, each of which bring new complex and confusing demands—new teachers, many new rooms, and often much larger

groups of students (Simmons et al., 1987); 5) Mounting decisions about the future are emerging. Many of these underline difficult dilemmas about current and later school plans, relationships, and careers; 6) Most teenagers want to become more independent, more "free" from their parents. But, *at the same time*, they also yearn for continued, though transformed, relationships with each parent; 7) Peers are becoming more and more important. Intensified romantic and same sex relationships can be marked during these years, and may lead to simultaneous, sometimes clashing, wishes to have "space" as well as meaningful continued relationships with parents and other family members.

Each of these characteristics, which I have so briefly summarized, can be greatly expanded upon, and have been in thoughtful recent reviews. (The interested reader can find ample additional material in Feldman and Elliot, 1990; Hauser, 1991; Powers, Hauser and Kilner, 1989.) The important overall point to keep in mind is that just as the experiences that the adolescent boy or girl is having do not happen in a vacuum, and have a personal history, their impact is also felt by individuals surrounding him or her, especially parents.

The Adolescent and His or Her Parents

These complex processes and associated themes can readily aggravate existing relationship problems between parents and adolescents over such fundamental matters as power, control, intimacy, closeness, loyalty, and sexuality. Issues between parents, and between parents and their adolescent son or daughter, that have been dormant for many years may surface with great intensity. Or new concerns, never before observed in the "easy" relationship with mom and dad, may—to everyone's surprise—now appear. If these new problems are seriously mishandled, allowed to become pervasive for the adolescent and his or her family, a number of problematic trajectories can be launched during these years. Consider some of the well known troubling and unsettled difficulties so prevalent for teenagers: substance abuse, pregnancy, school failure, school drop out, delinquency, and violence. These are surely the dire negatives, the worst case scenarios. But we know that they are not rare problems.

Our study of 146 adolescents and their families (Hauser, 1991; Hauser et al., 1984) and other studies (e.g., Steinberg, 1987) reveal that adolescents can strongly influence their families, for reasons I have sketched above. Parents are confronted with rapidly growing bodies, budding and flourishing sexuality in their previously young girl or boy, new social and intellectual challenges being thrust at them by this formerly easy going child. Under the best conditions, the family is presented with highly rewarding opportunities for new dialogues and transformed relationships. Although the kaleidoscopic stresses and changes may be upsetting for child and parents, we know that teenagers do not generally simply want to *detach* or leave their families (Powers, Hauser and Kilner, 1989). Most studies demonstrate adolescent boys and girls wanting to both connect more intensively with peers and romantic partners *as well as* redefine and intensify their relationships with parents. This is not a zero-sum game—closeness is yearned for in many directions.

What do I mean by the best conditions for adolescents and their parents? Favorable circumstances include: absence of racism, other bigotry, and poverty; and the presence of parents who understand the need for a balance of *firmness* and *responsiveness* in dealing with their children, especially with their growing adolescent. Other optimal conditions are the absence of additional complicating circumstances, such as a chronic illness in the adolescent or parents, and the absence of legal difficulties or psychiatric disturbance in the adolescent or the parents. Fortunately, many families and adolescents live in these conditions.

Yet there are families who are not fortunate enough to fit this desirable picture. And when conditions are problematic, many consequences can follow: 1) Diminished parental supervision or monitoring, meaning less involvement of the parents in overseeing new experiences, and being unavailable to discuss dilemmas or apply clear limits when needed; 2) Fewer relationships to draw support from; 3) Diminishing structure and coherence within the family, for instance at mealtime, leading the bereft and lonely adolescent to seek greater satisfaction from close cliques, neighborhood gangs, and/or prematurely intense romantic and sexual relationships. At their worst, these premature relationships can lead to adolescent pregnancy or unwanted psychological injury; 4) Related to the pain from these troubled, disappointing relationships may be

the drugs and alcohol that the adolescent increasingly turns to in order to cope with new problems or please new friends who have become the sole source of support; and 5) Worsening performance at school, in part because of challenging authorities. But a second reason can be the teenager's losing any motivation to stay in school, either because his or her new peers share the same disinterest, also holding a discouraging view of the future; or because of the adolescent's belief in the decreasing relevance courses have for current life and the envisioned future.

Enhancing and Obstructing Adolescent Growth

In our book summarizing much of the early data from our longitudinal study, *Adolescents and Their Families: Paths of Ego Development* (Hauser, 1991), we conclude with ways that we think families can nurture or interfere with the growth of their teenage members.

Throughout our varied accounts of paths of adolescent development, we obtained many observations, and speculations, about the influences that flow between adolescents and their parents. Four themes stood out as especially important, and generating conclusions about how families can nurture or interfere with the new growth of their adolescent members: 1) *Enduring engagement.* Repeatedly, we noticed the importance of parents and other family members "hanging in," especially when they are most tempted to leave. Enduring and even making authentic attempts to engage with an abusive and rejecting son or daughter may be one of the most meaningful acts that a father or mother can perform during their teenager's complicated and problematic years. 2) *Parental disclosure.* This idea refers to the parent's special role as a teacher. Disclosing, at the right moments, aspects of his or her inner life, offering—in ways that a son or daughter can grasp—pictures of their own history, views, understandings and current states of mind, can enhance their adolescent's development by revealing other ways of approaching and grasping experience. So, too, these special communications can bring poignant confirmation to the adolescent of his or her unique relationship with the parent who is so willing to share this less accessible knowledge. 3) *Tolerance of novelty, ambiguity, and uncertainty.* The chances of a teenager experimenting with new ideas and embracing new perceptions are greatly increased when he or she is in a family where curiosity and open-mindedness are valued, and uncertainty is tolerated. Many of our observations of teenagers highlighted the significance of this family quality, a characteristic that was especially striking in our observations of the parents of teenagers who appeared to be rapidly advancing in their development. 4) *Tolerance of unwanted and unexpected emotions.* Being willing and able to weather storms of disruptive and at times deeply offensive feelings, such as intense anger and rejection, is an important parental characteristic, one especially called upon during the adolescence of one of its members. Trenchant rejections, surprising and "inappropriate" mood swings erupt during these years. This parental strength, tolerating massive and unbidden feelings, is closely related to the idea of "hanging in."

Policy Implications: Parent Education

When we consider what a parent or family needs in order to express and implement these strengths, we arrive at a picture that includes time and energy to be thoughtful and reflective; and having the self esteem and steadiness to withstand unexpected provocative onslaughts that are not easily handled. How can parents be helped in this critical developmental period, during which sons and daughters may make crucial turns in their development, from which it may be extremely hard, if not impossible, to turn back. Helping parents in these circumstances requires multi-pronged programs. Two over-arching characteristics characterize such programs: They must be *required* whenever possible; and occur over an extended period of time. It is unlikely that brief, several-session exposures or "lessons" can possibly bring about the relevant knowledge or relation experience that parents need for handling these very complex years. There are two settings within which programs of *parent education* can meaningfully be offered:

I. The School

A. Parent *support* and *education groups* can be formed at first by the schools and affiliated programs working within them. For example, the Manville School at the Judge Baker Children's Center in Boston includes speakers and group meetings, as well as

home visits. Even before there are signs of trouble, these groups of parents can be meeting with an expert. They should be a *built in* aspect of the transition to high school, continuing with parent groups that have been meeting before as one of the conditions of the child being a student in the school. It is important that these groups be led by an *expert* with specific content, so they do not deteriorate into "adolescent bashing" discussions, rather than ways of learning about the complexity of the teenager's experience;

B. At the same time, the students should be having formal courses about family life and family relationships during teenage years, and an understanding of some of the psychosocial (rather than only biological) stresses and experiences that impinge upon teenagers;

C. *Special* programs for parents when crises erupt, such as new instances of drug abuse or addiction, pregnancy of a teenage daughter, or unexpected gang or violence experience. Formation of these special groups is much easier if structures are already in place for the ongoing groups. Although elements of these special programs may have existed in ongoing parent groups, it is important that when specific crises begin, groups of similar parents be able to express their feelings and concerns, and grasp together the nature of the new crisis;

D. Specific *educational programs* on violence, drugs, pregnancy, and school failure, that are woven into the ongoing work of the parent groups.

II. The Work Place

A. Continuing education groups within the work situation, led by knowledgeable psychologists and educators. These groups may be more effective in reaching some parents, since they will be occurring at work and may be more comfortable for particular parents to attend with co-workers and friends;

B. The presence of *flexible work hours* which permit parents to be away from work (and at home and accessible) during potentially problematic times—late afternoon and at dinner time and early evening. I am not necessarily recommending parental leave, except in extenuating circumstances. Rather, my idea is to promote increased flexibility in work settings. As a society, we have become increasingly sensitive to providing maternal and paternal leave at the time of birth. Adolescence is another time when such provisions are important, considering the long range costs of disastrous experience during these intense, complex, and potentially problem-full years;

C. The presence of counselors and other educated helpers, accessible for ongoing consultation, and then more frequently as new problems and crises arise.

The Larger Society

These reflections about how parenting may be enhanced—so that it will not interfere, obstruct, or aggravate the greatest difficulties during the teenage years—come largely from our own experience with white middle class teenagers, living with both parents. But what about adolescents of color, those living in single parent homes, and those from economically disadvantaged families? There is no reason to assume that relationships with parents are necessarily more troubled or radically different in such families. On the other hand, there is evidence of many *additional stressors* impinging upon parents, ranging from inflexible work hours that do not allow them to be home to supervise as much as possible, to strains created by unemployment and poverty. Given such strains and other sources of problems in these settings, we must especially focus on how social and economic forces can effect parents and developmentally important family relationships. While the connections between parenting and adolescent development in other social contexts remain to be explored, it would be questionable for us to wait for such knowledge before acting to impart what we believe is *effective parenting* during the adolescent years. A pressing research frontier is the study of how socially diverse families influence and respond

to the development of their adolescent children. A *pressing social need* is to effectively and energetically harness all that we know about adolescent development and *parenting adolescents* so as to aid baffled and helpless parents, trying their best to understand the seemingly impossible times and struggles they are encountering with their children. Only through aiding these parents can we hope to stem the tide of major, possibly irreversible, risks associated with the adolescent years.

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Full Service Schools

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All of us share concerns about the future of American youth and the role of parents in assuring their children's safe passage from childhood to adulthood. We have a good understanding of ways that parents can be helped to communicate with, instruct, nurture, and even enjoy their children. But not all parents have equal access to the social and economic strengths that guarantee healthy outcomes for all young people.

As families encounter increased difficulties assuming parental roles, other institutions are called on to assist. Schools become the recipients of children who are not ready to learn, who are not receiving adequate attention, and who place burdens on educators that they are not prepared to shoulder. As the Committee for Economic Development (CED) recently attested, "Schools are not social service institutions; they should not be asked to solve all our nation's social ills and cultural conflicts." Nevertheless, CED supports the *placement* of social services in schools, *delivered* through schools, but under no circumstances *funded* by educational systems.

The CED statement provides the underlying hypotheses of the concept of "full service schools." This phrase is used here to characterize schools as open to the provision of an array of diverse services in their buildings, services brought in by outside health, social service, and youth agencies. I first came across the term in Florida's 1991 innovative legislation that requires the state Board of Education and the Department of Health and Rehabilitative Services to jointly establish programs on school grounds.

The evolution of these new institutional arrangements—various types of full service schools—will be described along with their current impact on children and parents. Issues in replication—governance, turf, controversy, and funding—will be reviewed.

SOCIAL MOVEMENTS LEADING TO FULL SERVICE SCHOOLS

The concept of full service schools represents a fusion of several significant movements: improvement of adolescent health, school reform, and service integration for children and families. In 1991, Congress's Office of Technology Assessment issued a report on the health status of adolescents, documenting the consequences of the "new morbidities"—sex, drugs, violence, depression—and calling for greatly expanded access to comprehensive health care. They concluded that school-based health clinics were "a most promising recent innovation," excellent access points for young people to receive confidential primary health and social services, although they noted insufficient evaluation.

The movement toward school reform encompasses several goals that are especially relevant here: readiness for school, safe learning environments, adult literacy,and parental participation. None of these objectives can be accomplished without greatly expanding the scope of services offered in and around the school, for pre-school children as well as adults, after-school, evenings, and weekends in

addition to the school day. Title I (formerly Chapter I), which supports learning opportunities for disadvantaged children, has been revised to address the total school-community rather than just individual children who are pulled out of classrooms for occasional remediation. Around the country, new and successful educational programs have been created that build components such as family advocacy, mental health work, community service, and cultural enrichment on to school restructuring.

One theme that reverberates through every report on social development is the need to integrate services for children and families. For generations, the response to crises has been to create new categorical programs. Thus, each of the "new morbidities" has its own stream of funding, with different congressional supporters, grant requirements, and administrative housing. Young people have a hard time accessing these uncoordinated sectors. All families have to shop around for services, especially disadvantaged families who must go from place to place to seek welfare assistance, food stamps, child care, or employment help. The key word is "fragmentation"—the "patchwork quilt" of unrelated programs with different eligibility requirements, multiple data systems, and reimbursement mechanisms.

Connecting these movements together—the need to respond to the new morbidities, the drive to improve educational outcomes, and the thrust toward more comprehensive service delivery systems—provides the argument for full service schools. Schools are where most of the children can be found. Schools are where most of the families can establish contact with the people who educate their children and where they can obtain the help they need to be effective parents. If, at one site, one could produce quality education along with access to requisite health, social, and cultural services for children and families, both educational and psycho-social outcomes should be better. Figure 1 shows a feasible division of the turf: educational components on the left lie in the domain of the educational system; and health, social services, and other kinds of supportive programs lie in the domain of community agencies.

MODELS OF FULL SERVICE SCHOOLS

Each version of full service schools packages the components in different ways, moving along a continuum from simple to complex administrative arrangements. Relocation of a contract service from one site (a public health or social service department) to another (a school building) is much less complicated than the creation of a new type of community-school where the educational system and the support interventions are completely integrated and operated collaboratively by several agencies.

Figure 1 Components of Full Service Schools

Quality Education Provided by Schools	Provided by Schools or Community Agencies	Support Services Provided by Community Agencies
• effective basic skills	• comprehensive health education	• health screening and services
• individualized instruction	• health promotion	• dental services
• team teaching	• social skills training	• family planning
• cooperative learning	• preparation for the world of work, life planning	• individual counseling
• school-based management		• substance abuse treatment
• healthy school climate		• mental health services
• alternatives to tracking		• nutrition/weight management
• parent involvement		• referral with follow-up
• effective discipline		• basic services: housing, food, clothes
		• recreation, sports, culture
		• mentoring
		• family welfare services
		• parent education, literacy
		• child care
		• employment training/jobs
		• case management
		• crisis intervention
		• community policing

School-based Primary Health Care Clinics

The simplest model is the school-based clinic (SBC), a designated center within a school building that delivers comprehensive health, mental health, and social services to the student body. The provider is typically a local health department, community health center, medical facility, or a youth-serving agency. Staff includes nurse practitioners, social workers, clinic aides, and part-time physicians, with after-hours medical backup assured by the provider agency. In a few school systems, the Board of Education directly operates the medical services, but this is rarely feasible because of insurance, personnel, and backup requirements.

SBCs, after a slow start, are proliferating rapidly, increasing over the past decade from 10 locations to nearly 700. Although the earlier models were in urban high schools, the growing recognition of the importance of early intervention has generated replication in middle and elementary schools. School districts along with community agency partners are responding eagerly to Requests for Proposals (RFPs) promulgated by states using Maternal and Child Health Block Grant funds and other state initiatives, foundations, and most recently, the Bureau of Primary Health Care which awarded the first 25 direct federal grants to SBCs this year. As these school centers open, students crowd in with a profusion of complaints ranging from respiratory diseases and menstrual cramps, accidents and injuries, to personal crises and family problems. At the clinic, they receive physical examinations, immunizations, pregnancy and STD (sexually transmitted disease) tests, and individual counseling. SBC staff run group counseling workshops in the school on relevant subjects such as living with asthma, substance use, bereavement, sexual abuse, weight control, pregnancy prevention, and family relationships. SBC staff may also offer health education and health promotion curricula in the classroom. Parental consent is required for enrollment in these programs, and families are involved when appropriate. Parents are usually present at physical examinations in elementary schools.

School-based Youth Service Centers

The state of New Jersey Department of Human Resources pioneered the "one stop" concept with their School-Based Youth Services Program beginning in 1987. Grants have been awarded to 29 communities to develop joint school-community agency partnerships to bring core services into school centers. As the programs have evolved, each has a different configuration reflecting the needs in the schools and the skills of the community agencies.

Some centers focus more on coordination and referral than co-location of services in schools. Kentucky's significant school reform initiative in 1988 called for the development of youth service centers in high schools with more than 20 percent of the students eligible for free school meals. In this case, small grants were given to school systems to set up a designated room in the school with a full time coordinator to oversee referrals to community agencies for health and social services and to provide on-site counseling related to employment, substance abuse, and mental health.

Family Service/Resource Centers

The Kentucky legislation also called for family resource centers in elementary schools, which would offer parent education, and refer parents to infant and child care, health services, and other community agencies. In other states, family resource centers are being supported through various state initiatives and federal grants that deliver comprehensive services on school sites, including parent education, child care, counseling, health services, home visiting, and career training. At the New Beginnings Center at the Hamilton school in San Diego, operated by a collaborative created by several public agencies, family service advocates are assigned to each family unit.

Beacons

In New York City, an interesting version of full service schools was created by the city youth agency. Community-based agencies receive support to create "lighted school houses," open from early morning till late at night, as well as weekends and summers. These Beacons offer a wide range of activities, depending on the neighborhood needs, including after-school recreation, educational remediation, community events, and health services. Beacons were used as the prototype for the Family and Community Endeavors part of the 1994 Crime Bill, based on the belief that offering after-school activities in high risk communities would help prevent delinquency.

Community Schools

In the past, the phrase community-school has been applied mainly to adult education classes in school buildings. The new generation of community-schools begins to satisfy the broader construct (Figure 1), the integration of quality education with support services. Several schools have been identified as potential models (IS218, PS 5 and Children's Aid Society in New York City, Robertson and Hanshaw in Modesta, California, Farrell School System in Pennsylvania, Turner School in Philadelphia). What these community schools have in common are: restructured academic programs integrated with parent involvement and services for parents, health centers and family resource rooms, after-school activities, cultural and community activities, and open all hours and days. Each of these community schools is striving (in different ways) to become a village hub, with joint efforts from school and community agencies to create as rich an environment as possible for the children and their families.

Comprehensive School-based and School-linked

It is difficult to create a typology of full service schools because of the many models, and even models within models (e.g., clinics and resource centers within community schools). Foundation and state initiatives have shaped these structures. The Robert Wood Johnson Foundation (RWJ) has recently awarded grants to states for Making the Grade, stimulating state agencies to work together to promote school-based primary health care and school districts to create model programs. RWJ favors a medical model with local grants to health agencies outside of schools. California's Healthy Start Support Services for Children Act of 1991 program has produced an array of innovative, comprehensive, outcome-focused, family focused, school-based and school-linked health, social, and academic support programs. No single model has been favored.

PRELIMINARY RESEARCH ABOUT FULL SERVICE SCHOOLS

Support for the concept of full service schools is strong, but even the most ardent advocates want to be assured that centralizing services in restructured schools will make a difference in the lives of the children and their families. Evaluation results are spotty, not surprising given the early stages of program development and the difficulties inherent in program research. Much of the research has been on school-based clinics. Several of the states (Florida, Kentucky, California) are beginning to produce reports on more comprehensive programs.

In general, programs are located in the communities and schools with the greatest needs. School clinics are providing access to the highest risk students with the greatest number of problems and no other source of medical care. In centers with mental health personnel, substantial numbers of students and their families are gaining access to psycho-social counseling. The demand is overwhelming.

Use of emergency rooms has declined in areas with school clinics. Because minor illnesses such as headaches, menstrual cramps, and accidents on school property can be treated in school, absences and excuses to go home have decreased. School-based clinics have demonstrated the capacity to respond to emergencies, for example, conducting immunization campaigns and tuberculosis screening.

Scattered evidence suggests that a few school-based clinics have had an impact on delaying the initiation of sexual intercourse (abstinence), upgrading the quality of contraceptive use, and lowering pregnancy rates, but only in programs that offer comprehensive family planning services. Large numbers of students are being diagnosed and treated for sexually transmitted diseases. In some schools, clinic users have been shown to have lower substance use, better school attendance, and lower dropout rates. Having a clinic in a school has no proven effect on non-enrollees, and rates of problem behaviors in the total school have not changed significantly. This suggests that targeting high risk students is a cost-effective strategy. Comprehensive school-based programs for pregnant and parenting teens have demonstrated earlier access to prenatal care and higher birth weights, lower repeat pregnancy rates, and better school retention.

Students, parents, teachers, and school personnel report a high level of satisfaction with school clinics and particularly appreciate their accessibility, convenience, confidentiality, and caring attitudes. In family resource centers with health clinics, preventive medical care and treatment of minor

illnesses are the major services sought and used. In some programs, school staff also receive health screening, nutrition, and other services.

Early reports from the more comprehensive community-schools (mentioned above) are encouraging. Attendance and graduation rates are significantly higher than in comparable schools, and reading and math scores have shown some improvement. Students are eager to come to schools that are stimulating, nurturing, and respectful of cultural values. Parents are heavily involved as classroom aides, advisory board members, in classes and cultural events, with case managers and support services.

Although the models mentioned here—clinics, centers, community schools—have many differences, research has yielded a number of common components of successful programs. School and community people (local agencies, parents, leaders) join together to develop a shared vision of new institutional arrangements. An extended planning process starts off with a needs assessment to insure that the design is responsive to the requirements of the students and their families.

The configuration of support services brought in from the outside is dependent on what already exists in the school in the way of health, social services, and counseling. The building principal is instrumental in the implementation and smooth operation of full service schools. He/she not only acts as the leader in school restructuring, he must also be the prime facilitator for assuring smooth integration of the outside partners into the school environment. Adequate space must be made available, with security and maintenance.

In addition to the principal, successful programs rely on a full-time coordinator or program director. All personnel are trained to be sensitive to issues related to youth development, cultural diversity, and community empowerment. Bilingual staff are essential. A designated space such as a clinic or a center in a school acts as an anchor, or even a magnet, for bringing in other services from the community. Perhaps the most important effect of entering into the full service schools process is the capability of the new entity to bring new resources into the school building.

ISSUES IN REPLICATION

Governance

As would be expected, the more complex the model, the more demanding the administrative arrangements. The mounting rhetoric calls for sophisticated collaborative organizations, whereby school systems and community agencies leave behind their parochial loyalties and pitch in together to form a new kind of union. In reality, most of the emerging models have one designated lead agency. If it is the school system, as in Modesta, California, it dispenses its Healthy Start grant to a whole array of public and voluntary agencies through contractual relationships. In other places such as New Jersey, community agencies may be direct grantees and enter schools through a memorandum of agreement. But in neither case is governance changed.

The first evaluation of New Beginnings in San Diego, warns that it is "difficult to overestimate the amount of time collaboration takes." The participants discovered that it was easier to get agencies to make "deals" (sign contracts to relocate workers) than to achieve major changes in delivery systems. Staff turnover, family mobility, fiscal problems, and personality issues were cited as some of the barriers to change.

Turf

An issue related to governance is turf: who owns the school building? When a whole new staff working for an outside agency moves on to school property, many territorial concerns arise. What role does the school nurse play in the school-based clinic? Why not hire more school social workers if family counseling and case management is needed? Issues arise over confidentiality, space, releasing students from classes, and discipline. It takes time and energy and, particularly, skilled principals and program coordinators to work through appropriate policies and practices.

Controversy

In the earlier years, communities and school boards expressed resistance to the idea of school-based clinics and, in some places, just the idea of using the school building for anything but educational purposes was perceived as controversial. Experience throughout the country has shown that this

resistance has dissipated rapidly with the availability of state and foundation grants for comprehensive school health and social services. The extensive local needs assessments and planning prior to program development have equipped parents and school personnel with the necessary data to convince decision-makers and educate the media about the importance of integrating services in the school.

Funding

The annual cost for these full service school models ranges from $75,000 for Kentucky's Youth and Family Service Centers to $800,000 for the most comprehensive community-school. School-based clinics average about $150,000 per year, not including large amounts of in-kind and donated goods and services. The cost for a clinic user is about $100 per year while the incremental cost for a student in a community-school might be about $1,000. As we have seen, states are major funders of these initiatives and, even with looming budget cuts, are moving ahead to support more comprehensive school-based programs. Except for the initiative in the Bureau of Primary Health Care, no federal grants go directly to communities and schools for integrated services. However, the full service school concept has been recognized in significant new legislative endeavors including the crime bill, Title I, versions of health reform, and the new Empowerment Zone grants. Federal regulations could be changed to facilitate the increased use of categorical dollars, for example from Drug Free Schools, HIV prevention, special education, substance abuse and mental health programs. Medicaid is already being accessed in many schools although providers experience difficulties both with eligibility determination and reimbursement procedures. The advent of managed care adds to the complexity, with providers struggling to establish either fee-for-service or capitation contracts with managed care providers. State and federal health care reform legislation should guarantee that school-based centers can become "essential community providers" and that enrollees in managed care plans can obtain mental health, health education, and other preventive services within these plans.

THE FUTURE

The full service school is a home-grown product with many variants, developed at the local level by committed individuals who come together from diverse domains to try to build more responsive institutions. Relatively small investments by state governments and foundations enable innovative leaders to better use existing categorical resources to relocate personnel and devise more integrated delivery systems. Research will confirm that combining prevention interventions with school restructuring will create stronger institutions and schools will become neighborhood hubs, places where children's lives are enhanced and families want to go. We know that the school's role is to educate and the family's responsibility is to raise the children. Many of today's parents need assistance in accomplishing that task. Full service schools may be the most effective arrangement for achieving school, family, and societal goals.

The Challenge of Parenting in the '90s

February 17–20, 1995
Naples, Florida

List of Participants

Members of Congress

Senator Barbara Boxer
Senator Hank Brown
Representative Michael Castle
Representative William Clinger
Representative Jim Greenwood
Representative Sander Levin
Representative Jim McCrery
Representative George Miller
Representative Connie Morella
Representative John Porter
Senator Paul Sarbanes
Representative Tom Sawyer
Representative Patricia Schroeder
Representative Pete Stark
Representative Louis Stokes

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The Challenge of Parenting in the 90s

Agenda

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The Challenge of Parenthood
David A. Hamburg, Carnegie Corporation of New York

Preparation for Parenthood
Sarah S. Brown, National Academy of Sciences
David Olds, University of Colorado

Discussion Questions:
- How can people be helped to reach their own goals of planning for a family? What is the appropriate role of government in this process?
- What can help all young people prepare for parenthood? In developing programs, what are the key lessons that parents need to learn to become good parents? What are the promising lines of inquiry? What in-school programs can help?
- What are the essential principles and/or components of programs to teach effective parenting skills?

Pregnancy: A Learning Opportunity Beyond Medical Care
Ezra C. Davidson, Jr., King/Drew Medical Center

Building Parental Competence
Sharon L. Kagan, Yale University
Gloria G. Rodriguez, Avance Family Support and Education Program

Discussion Questions:
- How can parent education be included in every helping situation and community organization? What are the key operating principles to guide programs wherever they may be located — in minority communities, in rural areas, in inner cities? How do we build an infrastructure for parent education and support so that program quality is maintained?
- How do family support programs work? What are the essential elements of these programs? How can they be made available and supported in all communities?

- What are the characteristics of home visiting programs and how can they be implemented on a large scale throughout the country? What policies need to be in place to effect this expansion? How can home visiting support new parents and build parental competence? How can the programs be connected for mutual support?

Managing Multiple Roles of Parents: Work, Child Care, and Family

Eleanor E. Maccoby, Stanford University

Parenting Adolescents

Ruby Takanishi, Carnegie Council on Adolescent Development
Stuart T. Hauser, Judge Baker Children's Center

Discussion Questions:

- How important are involved parents to the healthy development of adolescents? What are the views of adolescents themselves? What can be the positive contribution of parents to the sound development of adolescents, based on current research?
- What kinds of programs would be helpful in preventing problems in parent-adolescent relationships? Why are these programs so limited and slow to develop? What can be done to improve the situation?
- What kinds of policies would be supportive of parenting during adolescence? What structured opportunities are there or could be developed for adolescents and parents to do things together?

Full Service Schools

Joy G. Dryfoos, Independent Researcher and Writer, Author of *Full Service Schools: A Revolution in Health and Social Services for Children, Youth and Families*